FIRST SENIORITY®

Harvard Pilgrim Health Care

Benefit Handbook

Your Medicare Health Benefits and Services for Group Insurance Commission Retiree Members of the Harvard Pilgrim Health Care, *First Seniority* Plan

Massachusetts

January 1 – December 31, 2004

Commonwealth of Massachusetts
Group Insurance Commission

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Harvard Pilgrim Member Services:

For help or information, please call Member Services weekdays. Hours of operation are: 8:00 a.m. - 7:30 p.m. on Monday and Wednesday, and 8:00 a.m. - 5:30 p.m. on Tuesday, Thursday and Friday. Calls to these numbers are free:

1-800-421-3550

TTY: 1-800-421-3599

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Welcome to *First Seniority*!

We are pleased that you've chosen *First Seniority*.

First Seniority is an HMO for people with Medicare

Now that you are enrolled in *First Seniority*, you are getting your care through Harvard Pilgrim Health Care (Harvard Pilgrim). *First Seniority*, an HMO, is offered by Harvard Pilgrim. ***First Seniority* is *not* a "Medigap" or supplemental Medicare insurance policy.**

This booklet explains how to get your Medicare services through *First Seniority*

This booklet, together with your enrollment form and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a Member of *First Seniority*. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2004, through December 31, 2004.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of *First Seniority*. This booklet gives you the details, including:

- What is covered in *First Seniority* and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan and when you get care.
- What to do if you are unhappy about something related to getting your Covered Services.
- How to leave *First Seniority*, including your choices for continuing Medicare if you leave.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with *First Seniority*. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Contents

How to contact *First Seniority* and other organizations

Section 1 Telephone numbers and other information for reference

How to contact Harvard Pilgrim **Member Services** 1

How to contact the **Medicare program** and 1-800-MEDICARE (TTY 1-877-486-2048) helpline 1

SHINE – an organization in your state that provides free Medicare help and information 2

Quality Improvement Organization (QIO) – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare 2

Other organizations (including Medicaid and the Social Security Administration) 3

How to get your health care services

Section 2 Getting the care you need, including some rules you must follow

What is *First Seniority*? 4

Use your plan membership card instead of your red, white, and blue Medicare card 4

Help us keep your Member records up to date 5

What is the geographic **service area** for *First Seniority*? 5

Using **plan providers** to get **Covered Services** covered by *First Seniority* 5

Choosing Your **PCP** (PCP means **P**rimary **C**are **P**hysician) 6

Getting care from your PCP 7

What if you need medical care when your PCP's office is closed? 7

Getting care from specialists 7

There are some services you can get on your own, without a referral 8

Getting care when you travel or are away from the plan's service area 8

How to change your PCP 8

What if your doctor leaves *First Seniority*? 8

Section 3 Getting care if you have a medical emergency or an urgent need for care

What is a "**medical emergency**"? 9

What should you do if you have a medical emergency? 9

First Seniority or your PCP will help manage and follow up on your emergency care 9

What is covered if you have a medical emergency? 9

What if it wasn't really a medical emergency? 10

What is "**urgently needed care**"? (this is different from a medical emergency) 10

Getting urgently needed care when you are in the plan's service area 10

Getting urgently needed care when you are outside the plan's service area 10

Your benefits and services

Section 4 Benefits Chart – a list of the Covered Services you get as a member of *First Seniority*

What are **Covered Services**? 11
There are some conditions that apply in order to get Covered Services 11
Benefits Chart – a list of Covered Services 12
Inpatient Services:
Inpatient hospital care 12
Inpatient mental health care 13
Skilled nursing facility care 13
Inpatient services (when the hospital or SNF days are not or are no longer covered) . 13
Home health care 14
Hospice care 14
Outpatient Services:
Physician services, including doctor office visits 15
Chiropractic services 15
Podiatry services 15
Outpatient mental health care 15
Outpatient substance abuse services 15
Outpatient surgery 16
Ambulance services 17
Non-Emergency Transportation 17
Emergency care 18
Urgently needed care 18
Outpatient rehabilitation services 18
Durable medical equipment and related supplies 18
Prosthetic devices and related supplies 19
Diabetes self-monitoring, training and supplies 19
Medical nutrition therapy 20
Outpatient diagnostic tests and therapeutic services and supplies 20
Preventive care and screening tests:
Bone mass measurements 21
Colorectal screening 21
Mammography screening 21
Pap smears, pelvic exams, and clinical breast exam 21
Prostate cancer screening exams 22
Immunizations 22
Other services:
Renal Dialysis (Kidney) 22
Drugs that are covered under Original Medicare 23

Additional benefits:

Prescription drug coverage 24
Dental services 25
Hearing services 25
Vision care 26
Routine physical exams 26
Health and wellness education programs 26
Family Planning and Maternity Services 27
Coronary Artery Disease (CAD) Programs 27

What if you have problems getting services you believe are covered for you? 28
Can your benefits change during the year? 28
Can the Harvard Pilgrim "Three-Tier Prescription Drug List" change during the year? 28

Section 5 Medical care and services that are NOT covered (list of exclusions and limitations)

Introduction 29
If you get services that are not covered, you must pay for them yourself 29
What services are **not** covered by *First Seniority*? 29

Section 6 Prescription drugs

How does the prescription drug benefit work? 32
How can you get a copy of the "Three-Tier Prescription Drug List"? 33
How and where do you fill your prescriptions? 34
Medications Covered by Original Medicare 37
Members residing in a Long Term Care Facility 38
Drug coverage policies, exceptions and exclusions 38
Claims Procedures 38
How to get help with questions or problems related to your prescription drug coverage 40

Section 7 Hospital care, skilled nursing facility care, and other services

Hospital care 41
Skilled nursing facility care (SNF care) 42
Home health care 43
Hospice care for people who are terminally ill 44
Organ transplants 45
Participating in a clinical trial 45
Care in Religious Non-medical Health Care Institutions 45

What you must pay

Section 8 What you must pay for your Medicare health plan coverage and for the care you receive

Paying the plan **premium** for your coverage as a member of *First Seniority* 46
Paying your share of the cost when you get Covered Services 46
You must pay the full cost of services that are not covered 47
Please keep us up-to-date on any other health insurance coverage you have 47
Subrogation 48
What should you do if you have bills from non-plan providers that you think we should pay? 48

Your rights and responsibilities

Section 9 Your rights and responsibilities as a member of *First Seniority*

Member Rights and Responsibilities 49
Introduction about your rights and protections 50
Your right to be treated with fairness and respect 50
Your right to the privacy of your medical records and personal health information 50
Your right to see plan providers and get Covered Services within a reasonable period of time 50
Your right to know your treatment choices and participate in decisions about your health care 51
Your right to use advance directives (such as a living will or a power of attorney) 51
Your right to make complaints 52
Your right to get information about your health care coverage and costs 52
Your right to get information about Harvard Pilgrim, *First Seniority*, and plan providers 52
How to get more information about your rights 52
What can you do if you think you have been treated unfairly or your rights are not being respected? 53
What are your responsibilities as a member of *First Seniority*? 53

What to do if you have problems or complaints

Section 10 Appeals and grievances: what to do if you have complaints

Introduction 54
What are **appeals** and **grievances**? 54
This section tells how to make complaints in different situations 55
PART 1. Making complaints (called “appeals”) to Harvard Pilgrim to change a decision about what we will cover for you or what we will pay for 55
PART 2. Making complaints if you think you are being discharged from the hospital too soon 57
PART 3. Making complaints if you think your coverage for SNF, home health or certified outpatient rehabilitation facility services is ending too soon. 59
PART 4. Making complaints (called “grievances”) about any other type of problem you have with Harvard Pilgrim, *First Seniority* or one of our plan providers 60

Section 11 Detailed information about how to make an appeal

What is the purpose of this section? 62
What are "complaints about your coverage or payment for your care"? 62
How does the appeals process work? 63
STEP 1: Harvard Pilgrim makes an *"initial decision"* about your medical care, or about paying for care you have already received 63
STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an *"appeal"* or *"request for reconsideration."* 66
STEP 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization ... 68
STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge 70
STEP 5: Your case may be reviewed by a Departmental Appeals Board 70
STEP 6: Your case may go to a Federal Court 70

How to leave *First Seniority*

Section 12 Leaving *First Seniority* and your choices for continuing Medicare after you leave

What is "**Disenrollment**"? 71
Until your membership officially ends, you must keep getting your Medicare services through *First Seniority* or you will have to pay for them yourself 71
What are your choices for continuing Medicare if you leave *First Seniority*? 72
When can you change your Medicare choices? 72
What should you do if you decide to leave *First Seniority*? 73
What happens to you if Harvard Pilgrim leaves the Medicare program or *First Seniority* leaves the area where you live? 74
You must leave *First Seniority* if you move out of the service area or are away from the service area for more than six months in a row 75
Under certain conditions Harvard Pilgrim can end your membership and make you leave the plan 75

Legal Notices

Section 13 Legal Notices

Notice about governing law 76
Notice about non-discrimination 76
Access to Information 76
Confidentiality 77
Evaluation of New Technology 77
Member Notices (Mailing Address) 78
Modification of This Benefit Handbook 78
Relationship of *First Seniority* Providers and Harvard Pilgrim 78
Benefits in The Event of Other Insurance 78

Section 13 Legal Notices (continued)
Workers' Compensation/Government Programs 78
Medical Payment Policies 78
Member Cooperation 79
Harvard Pilgrim's Rights 79

Definitions

Section 14 Definitions of some words used in this booklet
This section either gives a definition or directs you to a place in this booklet that explains the term 80

SECTION 1 Telephone numbers and other information for reference

How to contact Harvard Pilgrim **Member Services**.....1
How to contact the **Medicare program** and the1-800-MEDICARE (TTY 1-877-486-2048) helpline 1
SHINE– an organization in your state that provides free Medicare help and information 2
MassPro – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare.....2
Other organizations (including Medicaid and the Social Security Administration) 3

How to contact Harvard Pilgrim Member Services

If you have any questions or concerns, please call or write to Harvard Pilgrim Member Services. We will be happy to help you. Our business hours are 8:00 a.m. - 7:30 p.m. on Monday and Wednesday, and 8:00 a.m. - 5:30 p.m. on Tuesday, Thursday and Friday.

CALL **1-800-421-3550**. This number is also on the cover of this booklet for easy reference. Calls to this number are free.

TTY **1-800-421-3599**. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

WRITE Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169

How to contact the Medicare program and 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. The CMS contracts with and regulates Medicare Health Plans (including Harvard Pilgrim) and Medicare Private Fee-for-Service organizations.

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048 (you need special telephone equipment to use this number). Calls to these numbers are free.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information.** This website gives you a lot of up-to-date information about Medicare and nursing homes. It includes booklets you can print directly from your computer. It has a tool to help you compare Medicare managed care plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

SHINE– an organization in your state that provides free Medicare help and information

Serving Health Information Needs of Elders (SHINE) is a state organization paid by the Federal Government to give free health insurance information and help to people with Medicare. SHINE can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. SHINE has information about Medicare managed care plans and about Medigap (Medicare supplement insurance) policies. This includes information about special Medigap rights for people who have tried a Medicare+Choice plan (like *First Seniority*) for the first time. (Section 12 has more information about your Medigap guaranteed issue rights).

You can contact SHINE at Massachusetts Executive Office of Elder Affairs, One Ashburton Place, Boston, MA 02108. The phone number in your area is: 1-800-882-2003 or 1-800-872-0166 (TTY). You can also find the website for SHINE at www.medicare.gov on the web.

Quality Improvement Organization (QIO) – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In Massachusetts, the QIO is called MassPro. The doctors and other health experts in MassPro review certain types of complaints made by Medicare patients. These include complaints about quality of care, complaints from Medicare patients who think the coverage for their hospital stay is ending too soon and for Medicare patients who think the coverage of skilled nursing facility care, home health or certified outpatient rehabilitation facility services is ending too soon. See section 10 for more information about complaints.

You can contact MassPro at 235 Wyman Street, Waltham, MA 02154. The phone number in your area is 1-781-890-0011.

Other organizations (including Medicaid and the Social Security Administration)

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact the Division of Medical Assistance (Mass Health) at 1-800-841-2900 or 1-800-497-4648 (TTY) for the hearing impaired (you need special telephone equipment to use this number).

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit **www.ssa.gov** on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number is 312-751-4701 (you need special telephone equipment to use this number). You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

Call the Group Insurance Commission directly at (617) 727-2310 extension 801 if you have any questions about your plan premiums, or the open enrollment season.

SECTION 2 Getting the care you need, including some rules you must follow

What is *First Seniority*? 4
Use your plan membership card instead of your red, white, and blue Medicare card 4
Help us keep your Member records up to date 5
What is the geographic **service area** for *First Seniority*? 5
Using **plan providers** to get **services covered** by *First Seniority* 5
Choosing Your **PCP** (PCP means **P**rimary **C**are **P**hysician) 6
Getting care from your PCP 7
What if you need medical care when your PCP's office is closed? 7
Getting care from specialists 7
There are some services you can get on your own, without a referral 8
Getting care when you travel or are away from the plan's service area 8
How to change your PCP 8
What if your doctor leaves *First Seniority*? 8

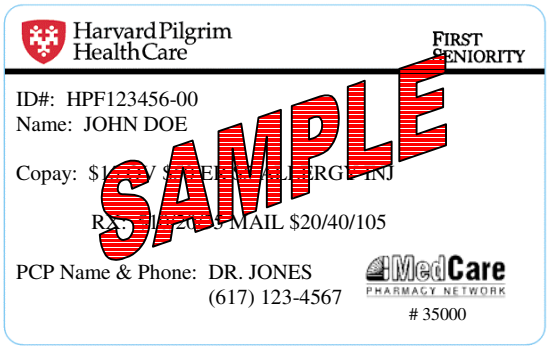
What is First Seniority?

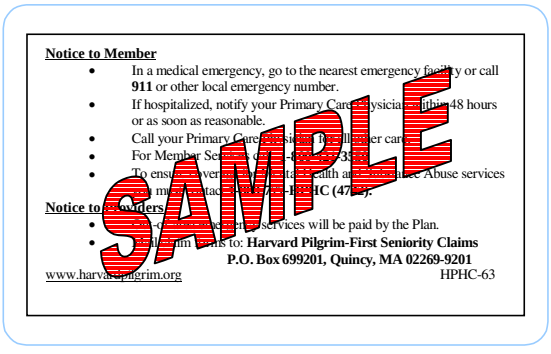
Now that you are enrolled in *First Seniority*, you are getting your Medicare through Harvard Pilgrim. *First Seniority* is offered by Harvard Pilgrim, and is an HMO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of *First Seniority*. (*First Seniority* is **not** a Medicare supplement policy. See Section 14 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called "Medigap" insurance policies.) Harvard Pilgrim provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. *First Seniority* gives you all of the usual Medicare services that are covered for everyone with Medicare. Since *First Seniority* is a Medicare HMO, this means that you will be getting most or all of your health services from the doctors, hospitals, and other health providers that are part of *First Seniority*. Since these doctors, hospitals, and other providers are the ones we are paying to provide your care, they are the ones you must use (except in special situations such as emergencies).

Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of *First Seniority*, you have a *First Seniority* membership card. Here is a sample card to show what it looks like:





During the time you are a plan member and using plan services, **you *must* use your plan membership card instead of your red, white, and blue Medicare card to get Covered Services.** (See Section 4 for a definition and list of Covered Services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a member. If you get services using your red, white, and blue Medicare card instead of your *First Seniority* membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your *First Seniority* membership card with you at all times. You will need to show this card when you get Covered Services. You *may* also need it to get savings on your prescriptions at the pharmacy. If your membership card is ever damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Help us keep your Member records up to date

Harvard Pilgrim has a file of information about you as a plan member. Doctors, hospitals, and other plan providers use this membership record to know what services are covered for you. The Member record has information from your enrollment form, including your address and telephone number. It shows your specific *First Seniority* coverage, the *Primary Care Physician* you chose when you enrolled, and other information. Section 9 tells how we protect the privacy of your personal health information.

Please help us keep your member record up to date by letting Member Services know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident. See Section 1 for how to contact Member Services.

What is the geographic service area for First Seniority?

The towns & cities in our service area are listed below.

Acton, Amesbury, Andover, Arlington, Ashland, Avon, Ayer, Bedford, Bellingham, Belmont, Beverly, Billerica, Boston, Boxboro, Boxford, Braintree, Brookline, Burlington, Cambridge, Canton, Carlisle, Chelmsford, Chelsea, Cohasset, Concord, Danvers, Dedham, Dover, Dracut, Dunstable, Essex, Everett, Foxboro, Framingham, Franklin, Georgetown, Gloucester, Groton, Groveland, Hamilton, Hanscom AFB, Haverill, Holbrook, Holliston, Hopkinton, Hudson, Ipswich, Lawrence, Lexington, Lincoln, Littleton, Lowell, Lynn, Lynnfield, Malden, Manchester, Manchester-by-the-sea, Marblehead, Marlboro, Maynard, Medfield, Medford, Medway, Melrose, Merrimac, Methuen, Middleton, Millis, Milton, Nahant, Natick, Needham, Newbury, Newburyport, Newton, Norfolk, N. Andover, N. Reading, Norwood, Peabody, Pepperell, Plainville, Quincy, Randolph, Reading, Revere, Rockport, Rowley, Salem, Salisbury, Saugus, Sharon, Sherborn, Shirley, Somerville, Stoneham, Stoughton, Stow, Sudbury, Swampscott, Tewksbury, Topsfield, Townsend, Tyngsboro, Wakefield, Walpole, Waltham, Watertown, Waverley, Wayland, Wellesley, Wenham, Westford, Weston, W. Newbury, Westwood, Weymouth, Wilmington, Winchester, Winthrop, Woburn, Wrentham

Using plan providers to get services covered by First Seniority

You will be using plan providers to get your Covered Services

Now that you are a member of *First Seniority*, with few exceptions, **you must use plan providers to get your Covered Services.**

- **What are "plan providers"?** "Providers" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "plan providers" when they participate in *First Seniority*. When we say that plan providers "participate in *First Seniority*," this means that we have arranged with them to coordinate or provide Covered Services to members of *First Seniority*. Please see section below titled "What is a PCP", for an explanation of how your PCP coordinates your care with specialists and within the *First Seniority* network.
- **What are "Covered Services"?** "Covered Services" is the general term we use in this booklet to mean all of the health care services and supplies that are covered by *First Seniority*. Covered Services are listed in the Benefits Chart in Section 4.

As we explain below, you will have to choose one of our plan providers to be your PCP, which stands for Primary Care Physician. Your PCP will provide or arrange for most or all of your Covered Services. Care or services you get from non-plan providers will not be covered, with few exceptions such as emergencies. (When we say "non-plan providers," we mean providers that are **not** part of *First Seniority*.)

The Provider Directory gives you a list of plan providers

Every year as long as you are a member of *First Seniority,* we will send you a Provider Directory, which gives you a list of plan providers. If you don't have the Provider Directory, you can get a copy from Member Services (see Section 1 for how to contact Member Services). You can ask Member Services for more information about plan providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in plan providers and about which ones are accepting new patients.

Access to care and information from plan providers

You have the right to get timely access to plan providers and to all services covered by the plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 9 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing Your PCP (PCP means Primary Care Physician)

What is a "PCP"?

When you become a member of *First Seniority,* you must choose a plan provider to be your PCP. Your PCP is a *health care professional* who meets State requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the Covered Services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

How do you choose a PCP?

Members must choose a PCP who practices in the state where the member resides. Therefore, when choosing your PCP, be sure to select a Massachusetts based PCP, by using the Provider Directory or getting help from Member Services. You can reach Member Services at **1-800-421-3550** (Hours of operation are 8:00 a.m. - 7:30 p.m. on Monday and Wednesday, and 8:00 a.m. - 5:30 p.m. on Tuesday, Thursday and Friday.) A Member Services representative will be happy to assist you. Hearing impaired Members can contact Member Services by calling the TTY Machine at **1-800-421-3599**. When you select your PCP, it is important to remember that this will limit you to the hospital, outpatient facilities and panel of specialists in the provider network contracted with your PCP. If there is a particular *First Seniority* specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital. The name and office telephone number of your PCP is printed on your membership card.

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. As we explain below and in Section 4, there are only a few types of Covered Services you can get on your own, without contacting your PCP first.

Besides providing much of your care, your PCP will help arrange or coordinate the rest of the Covered Services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of Covered Services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will also need to get prior authorization. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP's office. Section 9 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP's office is closed?

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. You do **not** have to contact your PCP or get permission in an emergency. You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your PCP or get medical care when the PCP's office is closed, and it is *not* a medical emergency, call your PCP's office number. There will always be a *health professional* on call to help you. This physician will call you back and advise you about what to do.

See Section 3 for more information about what to do if you have an urgent need for care.

Getting care from specialists

When your PCP thinks that you need specialized treatment, he or she will give you a referral (approval in advance) to see a plan specialist. A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). For some types of referrals to plan specialists, your PCP may need to get approval in advance from Harvard Pilgrim (this is called getting "prior authorization").

It is very important to get a referral from your PCP before you see a plan specialist (there are a few exceptions, including routine women's health care, that we explain later in this section). **If you don't have a referral before you receive services from a specialist, you may have to pay for these services yourself.** If the specialist wants you to come back for more care, check first to be sure that the referral you got from your PCP covers more visits to the specialist.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that **the *First Seniority* specialists you can use may depend on which person you chose to be your PCP.** You can change your PCP at any time if you want to see a plan specialist that your current PCP cannot refer you to. Later in this section, under "Choosing your PCP," we tell you how to change your PCP. If there are specific hospitals you want to use, find out whether *your PCP uses* these hospitals.

There are some services you can get on your own, without a referral

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the Covered Services you get as a plan member. If you get services from any doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a plan provider. *But there are a few exceptions:* you can get the following services on your own, without a referral or approval in advance from your PCP This is called "**self-refer**" when you get these services on your own.

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots and pneumonia vaccinations (as long as you get them from a plan provider).
- Routine vision care (Note: If you choose Harvard Vanguard Medical Associates as your provider, you can only go to their Visual Services Department for your routine eye exam and must obtain eyeglasses at Harvard Vanguard Optical Shops.)
- Emergency services, whether you get these services from plan providers or non-plan providers (see Section 3 for more information)
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible. (See Section 3 for more information about urgently needed care. Earlier in this section, we explain the plan's service area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area.

Getting care when you travel or are away from the plan's service area

If you need care when you are outside the service area, your coverage is limited. The only services we cover when you are outside our service area are care for a medical emergency, urgently needed care, renal dialysis, and care that Harvard Pilgrim or a plan provider has approved in advance. See Section 3 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Member Services at the telephone number on the cover of this booklet.

How to change your PCP

You may change your PCP for any reason. To change your PCP, call Member Services at the number shown on the cover of this booklet. When you call, be sure to tell Member Services if you are seeing specialists or getting other Covered Services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

What if your doctor leaves First Seniority?

Sometimes a PCP, specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of *First Seniority*. If your PCP leaves *First Seniority*, we will let you know, and help you switch to another PCP so that you can keep getting Covered Services.

SECTION 3 Getting care if you have a medical emergency or an urgent need for care

What is a "**medical emergency**"?....9
What should you do if you have a medical emergency?....9
First Seniority or your PCP will help manage and follow up on your emergency care....9
What is covered if you have a medical emergency?....9
What if it wasn't really a medical emergency?....10
What is "**urgently needed care**"? (this is different from a medical emergency)....10
Getting urgently needed care when you are in the plan's service area....10
Getting urgently needed care when you are outside the plan's service area....10

What is a "medical emergency"?

A "medical emergency" is when **you reasonably believe that your health is in serious danger** -- when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do <u>not</u> need to get permission first from your PCP (Primary Care Physician or other plan provider.** (Section 2 tells about your PCP and plan providers.)
- Make sure that Harvard Pilgrim or your PCP knows about your emergency, because Harvard Pilgrim or your PCP will need to be involved in following up on your emergency care. You or someone else should call to tell your PCP about your emergency care as soon as possible, preferably within 48 hours. The number to call is located on your *First Seniority* membership card.

First Seniority or your PCP will help manage and follow up on your emergency care

Harvard Pilgrim or your PCP will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we or your PCP will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world.
- **Ambulance** services are covered in situations where other means of transportation would endanger your health.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care -- thinking that your health is in serious danger -- and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" above).

- If you get any additional care after the doctor says it was *not* a medical emergency, we will pay our portion of the covered additional care **if you get it from a plan provider.**
- If you get any additional care from a *non-plan provider* after the doctor says it was not a medical emergency, we will usually *not* cover the additional care. There is an exception: we will pay our portion of the covered additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is "urgently needed care"? (this is different from a medical emergency)

"Urgently needed care" is **when you need medical attention right away for an unforeseen illness or injury,** and it is not reasonable given the situation for you to get medical care from your PCP or other plan providers. In these cases, your health is *not* in serious danger. As we explain below, how you get "urgently needed care" depends on whether you need it when you are in the plan's service area, or outside the plan's service area. Section 2 tells about the plan's service area.

What is the difference between a "medical emergency" and "urgently needed care"?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. "Urgently needed care" is if you need medical help immediately, but your health is not in serious danger. A "medical emergency" is if you believe that your health is in serious danger.

Getting urgently needed care when you are <u>in</u> the plan's service area

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan's service area, please call your PCP. There will always be a health professional on call to help you. Urgently needed services when you are in the plans service area are covered when these services are provided by your PCP or by a non-plan provider if and only if your PCP is temporarily unavailable or inaccessible. Keep in mind that if you have an urgent need for care while you are in the plan's service area, we expect you to get this care from plan providers. In most cases, we will not pay for urgently needed care that you get from a *non-plan provider* while you are in the plan's service area.

Getting urgently needed care when you are <u>outside</u> the plan's service area

First Seniority covers urgently needed care worldwide, that you get from non-plan providers when you are outside the plan's service area. If you need urgent care while you are outside the plan's service area, we prefer that you call your PCP first, whenever possible. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care through your PCP. However, we will cover follow-up care that you get from non-plan providers outside the plan's service area as long as the care you are getting still meets the definition of "urgently needed care."

As explained in Section 2, we cover renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area (for up to six months in a row).

SECTION 4 Benefits Chart – a list of the Covered Services you get as a member of *First Seniority*

What are **Covered Services**? 11
There are some conditions that apply in order to get Covered Services 11
Benefits Chart – a list of Covered Services 12
What if you have problems getting services you believe are covered for you? 28
Can your benefits change during the year? 28
Can the Harvard Pilgrim "Three-Tier Prescription Drug List" change during the year? 28

What are Covered Services?

This section describes the medical benefits and coverage you get as a member of *First Seniority*. **Covered Services means the medical care, services, supplies, and equipment that are covered by *First Seniority*.** This section has a Benefits Chart that gives a list of your Covered Services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are *not* covered** (these are called "exclusions"). Section 5 also tells about **limitations** on certain services. See Section 6 for information on the drug plan.

There are some conditions that apply in order to get Covered Services

Some general requirements apply to all Covered Services

The Covered Services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program and according to Harvard Pilgrim's guidelines for those services that *First Seniority* provides in addition to Medicare.
- The medical care, services, supplies, and equipment that are listed, as Covered Services must be medically necessary. Certain preventive care services and screening tests are also covered.
- With few exceptions, Covered Services must either be provided by plan providers, be approved in advance by plan providers, or be authorized by Harvard Pilgrim. The exceptions are care for a medical emergency, urgently needed care, and renal (kidney) dialysis you get when you are outside the plan's service area.

In addition, some Covered Services require "prior authorization" in order to be covered

Some of the Covered Services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets "prior authorization" (approval in advance) from Harvard Pilgrim. Covered Services that need prior authorization are marked in the Benefits Chart.

Benefits Chart – a list of Covered Services

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
INPATIENT SERVICES:	
Inpatient hospital care For more information about hospital care, see Section 7. Covered Services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services. • *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 7 for more information about transplants. • Blood—including storage and administration. • Physician Services. Note: For Definitions of Hospital Day and Benefit Period, please see Section 14.	• Care in an Acute Hospital is covered to the extent Medically Necessary. There is no limit on hospital days. • Care in a Rehabilitation or Long Term Hospital is covered up to 90 days per Benefit Period minus any other covered hospital days used in the Benefit Period under *First Seniority* or Original Medicare. Medicare Lifetime Reserve Days, if any, may also be used. • You pay $0 for each covered day in an acute hospital. Your 60 lifetime reserve days may be used for care in a Rehabilitation or Long Term Hospital. They may also be used for care in a Psychiatric Hospital when you have met the Medicare 190 day lifetime limit.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Inpatient mental health care Includes mental health care services that require a hospital stay.	• You pay $0 for each hospital stay.
Skilled nursing facility care For more information about skilled nursing facility care, see Section 7. Covered Services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood—including storage and administration. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services. Note: A 3-day prior hospital stay is not required.	• You pay $0 for up to 100 days per Benefit Period.
Inpatient services (when the hospital or SNF days are not or are no longer covered) The following services are covered when medically necessary during an inpatient stay, even if the stay itself is not covered by *First Seniority*. For more information, see Section 7. • Physician services. • Diagnostic tests (like X-ray or lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy.	• You pay $0.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Home health care For more information about home health care, see Section 7. **Home Health Agency Care *when approved in advance (this service requires prior authorization)*** • Part-time or intermittent skilled nursing and home health aid services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies.	• You pay $0 for all covered home health visits.
Also: • Physician Services • Durable Medical Equipment – As covered by Medicare • Portable X-rays and EKGs • Laboratory Tests	• You pay $0.
Hospice care For more information about hospice services, see Section 7. Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. Home care is also covered.	• When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare, (see Section 7 for more information about hospice services).

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
OUTPATIENT SERVICES:	
Physician services, including doctor office visits • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Outpatient hospital services.	• You pay $10 for each Primary Care Physician office visit. • You pay $10 for each Specialist office visit. • You pay $10 for Physician services at an Ambulatory Surgical Center.
Chiropractic services • Manual manipulation of the spine to correct subluxation.	• You pay $10 for each visit.
Podiatry services • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	• You pay $10 for each visit.
Outpatient mental health care (Including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. There is no limit on the number of visits covered.	• You pay $0 for Partial Hospitalization services. • You pay $5 for each visit.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Outpatient substance abuse services	• You pay $5 for each group visit for group visits 1-20 each calendar year. • You pay $5 for each individual visit for visits 1-8 each calendar year. • You pay $25 for each individual visit for visits 9-20 each calendar year. • You pay 50% for each group or individual visit after the 20th visit each calendar year.
Outpatient surgery	• You pay $0 for each Medicare- covered visit or procedure performed in an ambulatory surgical center. • You pay $0 for each Medicare-covered visit or procedure to an outpatient hospital facility.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Ambulance services • Includes ambulance services dispatched through 911, where other means of transportation could endanger your health. • Air ambulance is only covered in the following circumstances: A. For emergency air transport: 1. You require hospital care in a medical emergency, 2. No nearby facility can provide the care you need, 3. Transport by air ambulance is the only medically appropriate transportation option, and 4. You require immediate transfer from the air ambulance to an acute care hospital for admission as an inpatient. B. For human organ transplants, 1. You must be authorized to receive a human organ transplant outside the *First Seniority* service area. 2. Transport by air ambulance is the only medically appropriate transportation option. No coverage is provided for air ambulance transportation from the United States to a destination outside of the United States.	• You pay $0 for ambulance services.
Non-Emergency Transportation • Non-emergency transportation is limited to non-emergency ambulance transportation and wheel chair vans to or from a covered facility from home, and between covered facilities. Non-Emergency transportation is covered only when arranged by a Plan Provider or by Harvard Pilgrim and is medically necessary and reasonable • Non-emergency ambulance transportation is covered only when a Member is unable to get out of bed without assistance, unable to walk and unable to sit in a chair or wheelchair.	• You pay $0 for medically necessary non-emergency transportation

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Emergency care For more information, see Section 3. As a *First Seniority* Member you have worldwide coverage for emergency services.	• You pay $50 for each emergency room visit; you do not pay this amount if you are admitted to the hospital directly from the emergency room or within 3 days for the same condition.
Urgently needed care For more information see Section 3. As a *First Seniority* Member you have worldwide coverage for urgently needed services.	• You pay $50 for each emergency room visit; you do not pay this amount if you are admitted to the hospital directly from the emergency room or within 3 days for the same condition. • You pay $10for each visit to a physician's office.
Outpatient rehabilitation services (Physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy) Cardiac rehabilitation therapy covered when approved in advance (this service requires authorization) for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	• You pay $10 for each Medicare-covered Occupational Therapy, Physical Therapy and or Speech/Language Therapy visit. • You pay $10 for each covered Cardiac Rehabilitation Therapy visit.
Durable medical equipment and related supplies --Such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 14)	• You pay $0.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Prosthetic devices and related supplies --(Other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes devices following cataract removal or cataract surgery – see "Vision Care". You are covered up to $350 for a wig when medically necessary and ordered by a First Seniority Provider when you have hair loss due to treatment for any form of cancer or leukemia. Harvard Pilgrim covers formulas for treatment of malabsorption caused by Chron's disease, ulcerative colitis, gastroesophogeal reflux, gastrointestinal motility, or chronic intestinal pserdo-obstruction. Coverage is also provided for low protein foods for inherited diseases of amino acids and organic acids. This coverage is limited to $2,500 per Member per calendar year.	• You pay $0.
Diabetes self-monitoring, training and supplies --For all people who have diabetes (insulin and non-insulin users). Blood glucose meter, blood glucose test strips, lancet devices and lancets, and blood glucose control solutions for checking the accuracy of test strips and monitors. One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. Self-management training is covered under certain conditions.	• You pay $0 for test strips and lancets. • You pay $0 for blood glucose monitors including those with special features such as voice synthesizers, insulin pumps and supplies. • You pay $0 for therapeutic shoes for people with diabetes who have severe diabetic foot disease • You pay $10 for each medical nutrition therapy and self-management training visit.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Medical nutrition therapy --For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	• You pay $10 for services in a Physician's Office. • You pay $0 for services performed in an Outpatient Department of a Hospital.
Outpatient diagnostic tests and therapeutic services and supplies • X-rays. • Outpatient radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood – including storage and administration.	• You pay $0.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
PREVENTIVE CARE AND SCREENING TESTS:	
Bone mass measurements *For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary:* procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	• You pay $0.
Colorectal screening *For people 50 and older, the following are covered:* • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. *For people at high risk of colorectal cancer, the following is covered:* • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. *For people not at high risk of colorectal cancer, the following are covered:* • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. • Screening barium enema covered every 4 years.	• You pay $0.
Mammography screening (As explained in Section 2, you can get this service on your own, without a referral from your PCP, as long as you get it from a plan provider): • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	• You pay $0.
Pap smears, pelvic exams, and clinical breast exam (As explained in Section 2, you can get these routine women's health services on your own, without a referral from your PCP, as long as you get the services from a plan provider): • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 12 months.	• You pay $0.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Prostate cancer screening exams ***For men over age 50, the following are covered once every 12 months:*** • Digital rectal exam • Prostate Specific Antigen (PSA) test	• You pay $0.
Immunizations • Pneumonia vaccine (as explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get the service from a plan provider) • Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider). • *If you are at high or intermediate risk of getting Hepatitis B*: Hepatitis B vaccine. • Other vaccines if you are at risk (as covered by Medicare).	• You pay $0.
OTHER SERVICES:	
Renal Dialysis (Kidney) • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). • Inpatient dialysis treatments (if you are admitted to a hospital for special care. • Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply). • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and Erythropoietin (Epogen®) or Epoetin alfa.	• You pay $0.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Drugs that are covered under Original Medicare (these drugs are covered for everyone with Medicare) "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Harvard Pilgrim. (See Section 14 for a definition of "durable medical equipment"). • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectible osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Erythropoietin by self-injection if you have end-stage renal disease (permanent kidney failure); receive home dialysis; and need this drug to treat anemia. • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your residence. Coverage for outpatient prescription drugs is very limited. The drugs covered under Original Medicare are generally drugs that must be administered by a health professional. In addition to the drugs listed here that are covered under Original Medicare, *First Seniority* offers an outpatient prescription drug benefit. This additional benefit is described in Section 6.	• You pay $0 for prescription drugs covered by Medicare.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
ADDITIONAL BENEFITS:	
***First Seniority* Prescription Drug Benefit (outpatient prescription drugs)** "Drugs" include substances that are naturally present in the body, such as blood clotting factors and insulin. **The *First Seniority* prescription drug benefit covers the following:** • Certain outpatient prescription drugs. Section 6 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 6 also tells about drugs that are not covered by this benefit as listed in the "Three-Tier Prescription Drug List". For more information, see *Section 6. This section explains the prescription drug benefit.*	For prescription drugs not covered by Medicare on plan approved list, you pay for each prescription refill: • $10 for generic drugs for up to a 30-day supply. • $20 for select brand drugs for up to a 30-day supply. • $35 for non-select brand drugs for up to a 30-day supply. • $20 for mail order generic drugs for up to a 90-day supply. • $40 for mail order select brand drugs for up to a 90 day supply. • $105 for mail order non-select brand drugs for up to a 90-day supply. • You may use any contracting pharmacy.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Dental services • Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. • Emergency dental care needed due to an injury to sound, natural teeth. All services, except for suture removal must be received within 72 hours of injury. Coverage is provided only for the following procedures when the Member has had a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely: 1. Extraction of seven or more teeth; 2. Gingivectomies (including osseous surgery) of two or more gum quadrants; 3. Excision of radicular cysts involving the roots of three or more teeth; 4. Removal of one or more impacted teeth. Serious medical conditions include, but are not limited to hemophilia and heart disease. *First Seniority* provides limited coverage of dental and/or oral surgery services for members with the following serious medical conditions: • For members undergoing radiation of the jaw • Members undergoing Bone Marrow or other Human Organ Transplantations No other dental services are covered.	• You pay $10 for covered office visits. • You pay $50 for services provided in the emergency room; you do not pay this amount if you are directly admitted to the hospital from the emergency room or if you are admitted to the hospital within 3 days for the same condition.
Hearing services • Diagnostic hearing exams.	• You pay $10 for covered office visits.
• Hearing aids	• You are covered for the cost of purchase and repair in full for the first $500 and at 80% of cost for amounts between $501 and $2,000 in a 24-month period. • There is no coverage in excess of $2,000 in a 24-month period.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Vision care • Outpatient physician services for eye care. • Routine eye exams are limited to one exam every 12 months. • *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older:* glaucoma screening once per year • One pair of eyeglasses (limited to $60 per frame not including cost of lens) or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (frames limited to $60) and replacements needed after a cataract removal without a lens implant. • *First Seniority* will pay up to $100 for a pair of eyeglasses every 24 months in addition to the coverage provided after cataract surgery.	• You pay $10 for each eye exam. • For frames and lens, any cost in excess of $100. • If you choose Harvard Vanguard Medical Associates as your provider, you can only go to their Visual Services Department for your routine eye exam and must obtain eyeglasses or post cataract glasses at Harvard Vanguard Optical shops.
Routine physical exams Covered annually	• You pay $10 for each exam.
Health and wellness education programs • Health education • Nutritional training • Smoking Cessation classes • International Fitness Club Network (IFCN) • Cholesterol Education Classes.	*First Seniority* offers discounts on a variety of health promotion services. Please call Member Services for details.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Family Planning and Maternity Services Harvard Pilgrim covers family planning (including infertility treatment) and maternity care. Your PCP must refer you for infertility treatment and is responsible for getting Harvard Pilgrim approval for the referral. However, the following services may be obtained from a *First Seniority* Provider without a referral. • One consultation of expectant parents • Family planning consultation • Genetic counseling • Prenatal care within the *First Seniority* Provider Area Coverage for delivery includes a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. (Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother.) ***Referral is necessary for infertility treatment.***	• You pay $10 for services in a Physician's Office. • You pay $0 for services performed in an Outpatient Department of a Hospital.
Coronary Artery Disease (CAD) Programs The Plan covers approved Coronary Artery Disease (CAD) programs for all Plan Members. These programs are designed to help Members who meet the program's defined criteria for CAD by supporting them in making lifestyle changes that can reduce cardiac risk factors. This benefit is available to Members with a history of heart disease. For information on these programs: Members enrolled with a PCP at one of the Harvard Vanguard Medical Associates health sites can call **(617) 421-2560**. All other Members with PCPs in Massachusetts should contact Specialty Case Management at **1-888-888-4742**, ext. 38583.	• In-Network: 10% Coinsurance of Reasonable Charge. • Out-of-Network: Not Covered

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a member, we want to help. Please call Member Services at the telephone number on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 10 for information about making a complaint.

Can your benefits change during the year?

The Medicare program has rules about when and how we can make changes in your benefits. **We can *increase* your benefits at any time during the calendar year** (the current calendar year is the period from January 1 through December 31, 2004). Here are some examples:

- If we decide to add a new benefit, this would be an increase in your benefits (even though you might have to pay something if you use the new benefit).
- If we decide to provide more of some benefit that you already have, this would be an increase in your benefits.
- If we decide to reduce the amount of a Copayment, coinsurance, or plan premium, this would also be an increase in your benefits because you would be getting the same benefits for less money.

If we decide to increase any of your benefits during the calendar year, we will let you know in writing. **The Medicare program does not allow us to *decrease* your benefits during the calendar year.** We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you in advance (in October 2004) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2005.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes.

Can the Harvard Pilgrim "Three-Tier Prescription Drug List" change during the year?

The Medicare program allows us to make changes in The Harvard Pilgrim "Three-Tier Prescription Drug List" at any time during the calendar year. As we explain in Section 6, the Harvard Pilgrim "Three-Tier Prescription Drug List" is a list of drugs. A change in our drug list could affect *which drugs are covered for you –or- how much you have to pay when you fill a covered prescription.* Note that the Harvard Pilgrim "Three-Tier Prescription Drug List" applies only to the Covered Services listed in the Benefits Chart under the heading that says, "*First Seniority* Prescription Drug Benefit (outpatient prescription drugs)."

SECTION 5 Medical care and services that are **NOT** covered (list of exclusions and limitations)

Introduction..... 29
If you get services that are not covered, you must pay for them yourself 29
What services are **not** covered by *First Seniority*? 29

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by *First Seniority*. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare

What services are not covered by First Seniority?

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or in Section 13 Legal Notices, **the following items and services are <u>not</u> covered by *First Seniority*:**

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 4.
2. Services that you get from non-plan providers, except for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-plan providers that is arranged or approved by a plan provider. See other parts of this booklet (especially Sections 2 and 3) for information about using plan providers and the exceptions that apply.
3. Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service.
4. Services that you get without prior authorization, when prior authorization is required for getting that service. (Section 4 gives a definition of prior authorization and tells which services require prior authorization.)
5. Services that are not reasonable and necessary under Original Medicare program standards. As noted in Section 4, we provide all Covered Services according to Medicare guidelines.
6. Emergency facility services for non-authorized, routine conditions that do not appear to a prudent layperson to be based on an emergency medical condition (See Section 3 for more information about getting care for a medical emergency).
7. Experimental or investigational medical and surgical procedures, equipment and medications, that are otherwise not covered by Original Medicare or covered under clinical trials. (See Section 7 for information on Participating in a Clinical Trial). Experimental procedures and items are those items and procedures determined by Harvard Pilgrim and Original Medicare to not be generally accepted by the medical community. When deciding if a service or item is experimental, Harvard Pilgrim will follow CMS' manuals, the local carriers policies, or will follow decisions already made by Medicare.

8. Surgical treatment of morbid obesity *unless* determined medically necessary by a Harvard Pilgrim Medical Director or designee or if covered by Original Medicare.
9. Private room in a hospital, *unless* medically necessary.
10. Private duty nurses.
11. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
12. Non-durable medical supplies unless (1) used in the course of diagnosis or treatment in a medical facility, (2) used in the course of authorized home health care, (3) used as a part of the functioning of a prosthetic device, or (4) used with durable medical equipment.
13. Exercise equipment.
14. Foot orthotics, except when Medically Necessary for the treatment of severe diabetic foot disease.
15. Hearing aid batteries and dentures.
16. Nursing care on a full-time basis in your home
17. Custodial care is not covered by *First Seniority unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
18. Homemaker services.
19. Charges imposed by immediate relatives or Members of your household.
20. Meals delivered to your home.
21. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
22. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury, disease, congenital defect, surgery or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
23. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.
24. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in Section 4) and is limited according to Medicare guidelines.
25. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
26. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").
27. Supportive devices for the feet. *There is an exception*: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").
28. Refractive Eye surgery, including laser surgery and orthokeratology, for correction of myopia hyperopia, astigmatism. Low vision aids and services.

29. Reversal of sterilization procedures; sex change operations; and non-prescription contraceptive supplies, devices and any form of surrogacy. However, medically necessary services for infertility are covered.
30. Acupuncture.
31. Naturopaths' services.
32. Services provided to veterans in Veteran's Affairs (VA) facilities. However, we will reimburse veterans for the cost sharing for emergency services they receive at a VA hospital, up to the amount that we charge for cost sharing under the plan.
33. Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Harvard Pilgrim or Medicare.
34. Hospice services in a Medicare-participating hospice are not paid for by Harvard Pilgrim, but reimbursed directly by Original Medicare when you enroll in a Medicare-certified hospice.
35. Any form of transportation, except as specifically stated in Section 4 of your Benefit Handbook.
36. Items and services which are required as a result of war, or an act of war, occurring after your Medicare effective date. This exclusion does not apply to items and services required because of an act of war which occurred prior to your entitlement to Medicare.
37. Services for which payment is required to be made by Workers' Compensation plan or an employer under state or federal law.
38. Electrolysis and biofeedback except as covered by Original Medicare.
39. Educational services (including problems of school performance) or testing for developmental, educational, or behavioral problems.
40. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement or therapy to restore function for a specific occupation.
41. Routine maternity care when you are traveling outside the *First Seniority* Provider Area.
42. Special equipment needed for sports or occupational purposes.
43. Services for which no charge would be made in the absence of insurance.
44. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs and hospital or other facility charges that are related to any care that is not a covered service under this Benefit Handbook (See Section 7 for information on Participating in a Clinical Trial). This exclusion does not apply to coverage of service due to complications resulting from non-Covered Services after discharge from a hospital.

If you feel that a decision to deny coverage was in error, you may file an appeal. Please see Sections 10 and 11 for a description of your appeal rights.

Section 6 Prescription drugs (this section gives additional information about the outpatient prescription drug benefit that is listed in the Benefits Chart in Section 4)

How does the prescription drug benefit work? 32
How can you get a copy of the "Three-Tier Prescription Drug List"? 33
How and where do you fill your prescriptions? 34
Medications Covered by Original Medicare 37
Members residing in a Long Term Care Facility 38
Drug coverage policies and exceptions 38
Claims Procedures 38
How to get help with questions or problems related to your covered services for prescription drugs coverage 40

As a Harvard Pilgrim *First Seniority* Member you have coverage for certain limited outpatient drugs and medical supplies under Original Medicare. In addition to these benefits, your *First Seniority* benefits include unlimited outpatient prescription drug coverage. Below is a description of your optional *First Seniority* prescription drug benefit.

Coverage for the Outpatient Prescription Drug Benefit

The Harvard Pilgrim *First Seniority* Prescription Drug Benefit is above and beyond the basic Original Medicare benefit.

With few exceptions, your prescriptions must be obtained from plan providers and must be filled at a plan pharmacy or through our mail order service. There is an exception for medical emergencies and urgently needed care. If it is a medical emergency or urgently needed care, we cover prescriptions you get from doctors who are not plan providers and prescriptions that are filled at non-plan pharmacies. Section 3 tells about care for a medical emergency and urgently needed care.

How does the prescription drug benefit work?

The *First Seniority* prescription drug benefit covers most prescription drugs and a small number of non-prescription drugs and medical supplies. To provide cost-effective benefits, covered prescription drugs are divided into three tiers with different Member Copayments. (The Copayment amounts are listed on your ID card.) There are also a small number of drugs that are not covered or for which coverage is limited. The Copayment categories and coverage limits are explained below:

Generic Drugs (Tier 1). "Generic Drugs" are produced and sold under their chemical names, rather than names of the companies that manufacture them. They contain the same active ingredients as brand name drugs but are available at a lower cost. The Food and Drug Administration (FDA) reviews Generic Drugs to assure that they are safe and effective. Some brand name drugs have a generic form and others do not. Harvard Pilgrim encourages the dispensing of Generic Drugs whenever possible. **Your Generic Drug Copayment is $10 for a 30-day supply at a participating pharmacy.**

Select Brand Drugs (Tier 2). Brand name drugs are marketed under a trademarked brand name, usually by only one manufacturer. "Select Brand Drugs" are brand name drugs selected by Harvard Pilgrim based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market. Your Copayment for Select Brand Drugs is higher than for Generic Drugs but lower than for Non-Select Brand Drugs, which are described below. **Your Select Brand Drug Copayment is $20 for a 30-day supply at a participating pharmacy.**

Non-Select Brand Drugs (Tier 3). There are brand name drugs that Harvard Pilgrim has not selected as Select Brand Drugs. These are called **"**Non-Select Brand Drugs." This category includes, but is not limited to, brand name drugs that have a generic equivalent. You pay the highest Copayment for Non-Select Brand Drugs. **Your Non-Select Brand Drug Copayment is $35 for a 30-day supply at a participating pharmacy.**

Although the *First Seniority* prescription drug benefit covers Non-Select Brand Drugs with a higher Copayment, there will usually be a Generic Drug or a Select Brand Drugs with a lower Copayment that is appropriate for your condition.

Generic drugs cost less, but generic and brand name drugs are the same in terms of quality and how they work. The law requires that a generic drug must contain the same amount of the same active drug ingredient as the brand-name drug to be interchangeable. However, a generic drug may differ in certain other ways, such as its color or its flavor, the shape of the pill or tablet, and the inactive (non-drug) ingredients it contains.

Drugs For Which Coverage is Excluded or Limited. There are a small number of prescription drugs that are either not covered by the *First Seniority* prescription drug benefit or for which coverage is limited. *First Seniority* Providers may request an exception on behalf of a Member for coverage of any drug that is excluded or limited. For more information see "Drug Coverage Policies and Exceptions," below.

The *First Seniority* prescription drug benefit covers only drugs that are medically necessary for preventive care or for treating illness, injury or pregnancy. (Drugs that are not covered include, but are not limited to, drugs for cosmetic purposes and weight loss.) Harvard Pilgrim also limits the coverage of specific drugs to control costs and to assure their safe and effective use. Limitations may be placed on either the quantity of a drug covered or the medical conditions for which a covered drug may be prescribed. For details on these limits, see the "Three-Tier Prescription Drug List".

The "Three-Tier Prescription Drug List" allows you to identify which drugs are Generic (Tier 1), Select Brand (Tier 2) and Non-Select Brand (Tier 3). Also listed are the drugs for which coverage is excluded or limited or which require prior authorization for coverage.

How can you get a copy of the "Three-Tier Prescription Drug List"?

You may obtain a copy of the "Three-Tier Prescription Drug List" by calling Member Services at **1-800-421-3550** (Hours of operation are 8:00 a.m. - 7:30 p.m. on Monday and Wednesday, and 8:00 a.m. - 5:30 p.m. on Tuesday, Thursday and Friday.) A Member Services representative will be happy to assist you. If you are hearing impaired, call **1-800-421-3599 (for TTY service)**, you need special telephone equipment to use this number. You may also go to the Harvard Pilgrim web site on the Internet at: **www.harvardpilgrim.org**

Harvard Pilgrim's Pharmacy and Therapeutics Committee is responsible for classifying drugs as Select Brand Drugs and for establishing exclusions and limitations on drug coverage. The Committee is made up of physicians and pharmacists who are advised by physician consultants from a large number of medical specialties.

How and where do you fill your prescriptions?

Whenever possible you should fill prescriptions at a Harvard Pilgrim participating pharmacy. If you use a participating pharmacy you will only have to show your Harvard Pilgrim ID card at the pharmacy and pay the applicable Copayment. If you do not use a participating pharmacy, you will have to pay the retail price for the medication and submit a claim for reimbursement.

Participating Pharmacies

There are over 45,000 Plan participating pharmacies in the United States, including:

- Brooks Pharmacy
- CVS/pharmacy
- Eckerd
- Harvard Vanguard Medical Associates Pharmacies
- Kmart Pharmacy
- Rite Aid
- Star Market
- Stop & Shop
- Walgreens
- Walmart
- Many independent drug stores

Information on participating pharmacies can be obtained from the Member Services Department by calling **1-800-421-3550**. If you are hearing impaired, call our TTY machine at **1-800-421-3599** (you need special telephone equipment to use this number). Members may also locate participating pharmacies, in any area of the country, online at www.harvardpilgrim.org. *Click* Pharmacy Program.

If you fill a prescription for a covered drug at a non-participating pharmacy, you will have to submit a claim for reimbursement. The reimbursement procedures for pharmacy items are explained in your Benefit Handbook in the section titled "Claims Procedures." Reimbursement for drugs purchased at non-participating pharmacies will be paid minus the applicable Copayment. Payment will be limited to the Usual, Customary and Reasonable Charge for the drug.

Filling certain prescriptions at a Plan Specialty Pharmacy

Harvard Pilgrim has designated pharmacies that Members must use to obtain certain specialty medications. These include drugs for the treatment of infertility, hepatitis C, osteoarthritis, multiple sclerosis, rheumatoid arthritis and certain hereditary diseases. A list of the drugs that must be purchased from the specialty pharmacies may be obtained on our website at www.harvardpilgrim.org (**click** Pharmacy Program, **then click either** Infertility Pharmacy Program **or** Specialty Pharmacy Program). **This information may also be obtained by calling our Member Services Department at 1-888-421-3550.**

The Plan's specialty pharmacies have expertise in the delivery of the drugs they provide. They maintain these medications in stock at all times and can deliver them by overnight mail with the medical supplies necessary for their use. In an emergency, same day delivery can also be provided. The specialty pharmacies will give Members instruction in the administration of the drugs they provide. Additional drugs may be added to the specialty pharmacy program from time to time.

Copayments to the specialty pharmacies is the same as at other participating pharmacies. The specialty pharmacies are not part of the Plan's Mail Order Prescription Drug Program, to which different cost sharing rules apply.

How much do you pay when you fill a prescription?

If you buy your prescriptions at a participating pharmacy, you pay the lower of the Copayment, the Discount Rate, or the pharmacy's retail price.

Your Copayments

Copayments are the amounts you must pay for covered medications. They are listed on the front of your ID card. As explained earlier in this section, different Copayments are charged for Generic Drugs (Tier 1), Select Brand Drugs (Tier 2) and Non-Select Brand Drugs (Tier 3). Copayments must be paid at the time of purchase. Members are required to share the cost of the benefits provided under the Plan. Your copayment can vary from $10 to $35, depending on the drug and whether you get the drug at a plan pharmacy or through our mail order service.

When a prescription or refill is purchased at a Harvard Pilgrim Contracting Pharmacy, each Copayment covers up to a 30-day supply. If your physician prescribes less than a 30-day supply of a medication, each Copayment covers the amount prescribed. If the applicable Copayment is more than the retail price of a drug, you pay the retail price.

In some cases, Harvard Pilgrim may limit the amount of a drug available per Copayment. Such limits are listed in the "Three-Tier Prescription Drug List".

Mail Service Prescriptions

Members who wish to receive their prescriptions through the mail may obtain them through the Harvard Pilgrim Mail Service Prescription Drug Program. Only maintenance medications for which a 90-day supply is appropriate may be obtained by mail. Since each Copayment for a prescription drug purchased through the Mail Service Program covers a 90-day supply, Generic and Select Brand Drugs cost less by mail. Your mail service Copayments are $20 for Generic Drugs, $40 for Select Brand Drugs and $105 for Non-Select Brand Drugs. These Copayments apply only to the Harvard Pilgrim Mail Service Prescription Drug Program and are different from the Copayments charged for drugs purchased at a Contracting Pharmacy.

The following items may not be purchased through the Harvard Pilgrim Mail Service Prescription Drug Program:

- Compounded medications requiring the mixing of drugs by a pharmacist;
- Any drugs for which mail service is prohibited by law;
- Prescriptions for which a 90-day supply may not be appropriate as determined by Harvard Pilgrim.

To obtain order forms or for more information about the Harvard Pilgrim Mail Service Prescription Drug Program, please contact the program directly at **1-877-347-3216 (TTY: 1-877-517-9301**).

Non-Participating Pharmacies

No benefits are provided for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.

If you fill a prescription for a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, then submit a claim for reimbursement from the Plan. The reimbursement procedures for pharmacy items are explained on Page 38. Reimbursement for drugs purchased at non-participating pharmacies will be paid minus the Copayment. Payment will be limited to the Usual, Customary and Reasonable Charge for the drug.

What is Covered

Your prescription drug benefit covers all Medically Necessary drugs that require a prescription by law, except drugs the Plan excludes or limits. Your benefit also covers the non-prescription items, listed below. All covered drugs are subject to the applicable copayment. Please check your Member ID card for the copayment amounts that apply to your drug coverage.

Your *First Seniority* prescription drug benefit covers the following prescription and non-prescription items:

Covered Prescription Items	*Covered Non-Prescription Items*
• Prescriptions, and refill prescriptions allowed by law and authorized by the prescribing physician • Needles and syringes needed to administer covered drugs • Contraceptive drugs and devices • Hormone replacement therapy (HRT) • Off-label uses of drugs, including drugs for the treatment of cancer and HIV/AIDS • Compounded prescriptions, as long as one or more agents within the compound requires a prescription	• Insulin • Nicotinic acid • Lancets • Blood glucose testing strips • Urine diabetic testing strips • Ketone diabetic testing strips • Am-lactin Lotion • Gyne-Lotrimin Vaginal Crème and Inserts

Medications Covered by Original Medicare

These medications are covered for all *First Seniority* members.

- Medications administered to *First Seniority* Members as part of a covered Hospital or a covered Skilled Nursing Facility stay.
- Medications, vaccines, and blood components administered in a *First Seniority* provider's office or Hospital Outpatient Department as incident to a physician service.
- Immunosuppressive drugs following a Medicare covered organ transplant (as long as the transplant was paid for by Medicare), certain oral anti-cancer drugs and anti-nausea drugs, antigens, self-administered erythropoietin, and injectible drugs for the treatment of osteoporosis for the home confined who cannot self administer.
- Drugs used with authorized durable medical equipment.

Generally, medications you can buy without a prescription are not covered by *First Seniority.*

Exclusions and limitations from coverage

First Seniority does not cover the following:

- Drugs that are not medically necessary for either preventive care or for the treatment of illness, injury or pregnancy
- Drugs that Harvard Pilgrim specifically excludes, including, but not limited to, drugs for cosmetic purposes and weight loss
- Drugs in excess of coverage limitations imposed by Harvard Pilgrim (Limitations may be placed on either the quantity of a drug covered or the medical conditions for which a drug may be prescribed.)
- Non-prescription items, other than those specifically listed above
- Drugs that have not been approved by the FDA
- Prescriptions written by providers who are not authorized to do so by Harvard Pilgrim, unless covered under the benefit for care outside the *First Seniority* Provider Area, such as for emergencies or urgently needed services.
- Drugs prescribed as part of a course of treatment that *First Seniority* does not cover
- Drugs that must be administered by a health care professional. (Such drugs may be covered through the provider but may not be purchased by a Member under the pharmacy benefit.)
- Drugs that must be obtained through The Specialty Pharmacy Program if not purchased from one of the programs specially designated pharmacies. The Specialty Pharmacy Program is described on page 34.
- Any sales tax or governmental assessment on pharmacy items

Emergency situations outside the *First Seniority* Provider Area

While you are temporarily outside of the *First Seniority* Provider Area, you are covered for prescription drugs needed for an unforeseen illness or injury. (See Pg. 8 of your Benefit Handbook for a description of your coverage when you are temporarily traveling outside the Provider Area.) In most cases you will have to pay for drugs you obtain outside the Provider Area and file a claim for reimbursement. Harvard Pilgrim's pharmacy benefit manager, ***MedImpact***, will reimburse you for the prescription, less the applicable pharmacy Copayment. Prescription drugs that you purchase while outside the Provider Area will be counted against the prescription drug benefit maximum except for the items listed under "Medicare Covered Drugs."

Please see the "Claims Procedures" section toward the end of this section for the procedure for filing claims for reimbursement.

Members residing in a Long Term Care Facility

You can use the prescription drug coverage described in this brochure when you reside in a long-term care facility and are receiving care that is not covered by *First Seniority*. (*First Seniority* covers drugs administered during a covered inpatient stay, including care in a Skilled Nursing Facility.) If you reside in a long-term care facility and are billed for prescription drugs, please pay the bill and submit a claim for reimbursement to Harvard Pilgrim's pharmacy benefits manager, ***MedImpact***. Please see the "Claims Procedures" section toward the end of this section for the procedure for filing claims for reimbursement. Reimbursement will be minus the applicable Copayment.

Drug coverage policies and exceptions

Harvard Pilgrim's Pharmacy and Therapeutics Committee is an advisory group that makes recommendations for the placement of drugs in Tier 2 (Select Brand) or Tier 3 (Non-Select Brand), as well as setting exclusions and limitations on drug coverage. The Committee is made up of physicians and pharmacists, who are advised by physician consultants from a large number of medical specialties.

Harvard Pilgrim regularly reviews and updates the Three-Tier drug list as new drugs or drug information becomes available. As a result, the tier placement of covered drugs may change at any time. Members can get an updated Three-Tier Drug List Brochure by calling the Member Services Department at **1-888-421-3550** or view it online at **www.harvardpilgrim.org**. Click **Pharmacy Program**.

Harvard Pilgrim may require prior authorization for coverage of certain drugs. Harvard Pilgrim may add to the list of drugs for which prior authorization is required or for which coverage is excluded or limited at any time, without prior notice to Members. Medical providers may request an exception on behalf of a Member for coverage of any drug that is excluded or limited. Exceptions may be granted only for clinical reasons. You may appeal denials of coverage for Prescription Drugs that Harvard Pilgrim does not cover. For further information on your appeal rights see Section 10.

Harvard Pilgrim will not grant individual exceptions to waive or reduce the Copayment for a particular drug, however medical providers may submit a request to the Plan to review a drug for placement in Tier 2 (Select Brand).

Claims Procedures

You may file a claim for reimbursement if you purchase drugs outside the Provider Area or reside in a long-term care facility. In all other situations, drugs must be purchased at a Harvard Pilgrim Contracting Pharmacy or through the Harvard Pilgrim Mail Service Prescription Drug Program.

When filing a claim, you may use the *First Seniority* Claim Reimbursement Form. To obtain a copy of this form please call the Member Services Department at **1-888-421-3550** or you may obtain a copy online at **www.harvardpilgrim.org**.

Claims for prescription drug reimbursement should be sent to Harvard Pilgrim's pharmacy benefit manager, ***MedImpact***. All claims should be sent to the following address with the information described below:

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

Please be sure to include all the following information, and the information requested below with all claims:
- Your name
- Your *First Seniority* ID number
- Your address
- Your telephone number
- Your date of birth

The information below is needed depending upon whether the claim you are submitting is for prescriptions obtained outside the Provider Area or prescriptions obtained at a long term care facility.

Claims for drugs purchased outside of the Provider Area

- A pharmacy receipt showing the name of the item purchased
- Date of purchase
- Pharmacy name, address, and phone number
- Prescription number
- Amount paid
- Prescribing doctor
- Quantity and number of days supplied

Claims for drugs provided in a long-term care facility

- A bill showing the dispensing date of the prescription
- Name of drug
- Strength and form of drug
- Quantity or days supplied
- Amount billed
- The National Drug Code (NDC) number
- If you are a Harvard Vanguard Medical Associates member

Please note that we may need more information for some claims.

Harvard Pilgrim will reimburse you for the prescription cost minus the applicable pharmacy Copayment.

Harvard Pilgrim has a 1-year filing limit.
You must submit your request for reimbursement for a prescription drug to MedImpact within 1 year of the date of purchase of your prescription. No payment for reimbursement will be made for outpatient prescription drugs beyond the 1-year filing limit.

How to get help with questions or problems related to your prescription drug coverage

To learn more about your prescription drug benefits, please call Member Services at the telephone number on the cover of this booklet. MedImpact is a company that helps handle prescription drug benefits for members of *First Seniority*. If you have any problems or concerns related to using your prescription drug coverage, please let us know by calling our Member Services Department at **1-888-421-3550**. If you are hearing impaired, call our TTY machine at **1-800-421-3599**. Members may also search for participating pharmacies in any area of the country on our website at **www.harvardpilgrim.org**. *Click* Pharmacy Program.

From time to time, Harvard Pilgrim may make decisions that affect your prescription drug coverage, such as whether a particular drug is covered for you, or whether we approve your doctor's request for an exception to the usual rules about prescription drug coverage. If you are unhappy about a decision we make about whether a prescription is covered, or the amount of payment for a prescription, you have the right to make an appeal (an appeal asks us to reconsider and change our decision about coverage or payment). If you want to make any other types of complaints related to your prescription drug benefit, you would file a "grievance." Section 10 discusses grievances and appeals. You can also call Member Services to get additional information or help with a grievance or appeal.

SECTION 7 Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the Covered Services that are listed in the Benefits Chart in Section 4)

Hospital care 41
Skilled nursing facility care (SNF care) 42
Home health care 43
Hospice care for people who are terminally ill 44
Organ transplants 45
Participating in a clinical trial 45
Care in Religious Non-medical Health Care Institutions 45

Hospital care

If you need hospital care, we will arrange Covered Services for you. Covered Services for hospital care are listed in the Benefits Chart in Section 4 under the heading "Inpatient Hospital Care." We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

First Seniority PCPs use particular hospitals and specialists that they refer to. Please see the section "How do you choose a PCP", on page 6 of this Benefit Handbook if there is a particular hospital or specialist that you want to use.

What is a "benefit period" for hospital care?

First Seniority uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital). A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. (Later in this section we explain about skilled nursing facility services).

What happens if you join or drop out of *First Seniority* during a hospital stay?

If you either join or leave *First Seniority* during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number listed on the cover of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to Harvard Pilgrim, if any, for the periods of your stay when you were and were not a plan member.

What is a "hospitalist"?

A hospitalist is a physician other than your PCP or the admitting specialist who specializes in treating patients when they are in the hospital and who may coordinate your care when you are admitted to a hospital. A hospitalist is either employed by the hospital or by the group of physicians to which your PCP belongs. There is communication between your PCP and the hospitalist at the time of your admission, during your hospital stay and when you are discharged. After discharge your PCP will resume caring for you. In some cases a specialist other than a hospitalist will be the attending physician in the hospital. You should ask your PCP what arrangements have been made for his/her practice.

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered Services are listed in the Benefits Chart in Section 4 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your Covered Services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services**. It can be a separate facility, or part of a hospital or other health care facility. A **s**killed **n**ursing **f**acility is called a "SNF" for short. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living).

When you need specialty care in a skilled nursing facility, your care will be coordinated and provided in a *First Seniority* contracted skilled nursing facility that is affiliated with your PCP.

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by *First Seniority* unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to *100* days each benefit period. A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in section 4 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

In some situations, you may be able to get care in a SNF that is not a plan provider

Generally, you will get your skilled nursing facility care from SNFs that are plan providers for *First Seniority*. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a plan provider. One of the conditions is that the SNF that is not a plan provider must be willing to accept Harvard Pilgrim's rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

Home health care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered Services are listed in the Benefits Chart in Section 4 under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health services?

To get home health care benefits, you must meet all of these conditions:

1. You must be **homebound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are on infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

   Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.
2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.

4. **You must need *at least one* of the following types of skilled care:**

   - Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
   - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
   - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
   - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

If you meet all four of these conditions for getting home health care, *First Seniority* covers either part-time or intermittent home health care services. As explained below, this means that there are limits on the number of hours per day and days per week that you can get home health services.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services and home health aide services.

- **"Part-time" or "Intermittent"** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of *First Seniority*, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Member Services at the number on the cover of this booklet to get a list of the Medicare-certified hospice providers in your area, or you can call the Regional Home Health Intermediary at 1-888-896-4997. (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Member Services to get information on your hospice coverage.)

If you enroll in a Medicare-certified hospice, Original Medicare (rather than *First Seniority*) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through *First Seniority*.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/ multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, such as how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not *First Seniority*) pays the clinical trial doctors and other providers for the Covered Services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in *First Seniority* and continue to get the rest of your care that is unrelated to the clinical trial through *First Seniority*. You will have to pay the Original Medicare coinsurance for the clinical trial services.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare's website.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by *First Seniority* under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. "Nonexcepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from *First Seniority*, or your stay in the RNHCI may not be covered.

SECTION 8 What you must pay for your Medicare health plan coverage and for the care you receive

Paying the plan **premium** for your coverage as a member of *First Seniority*..... 46
Paying your share of the cost when you get Covered Services..... 46
You must pay the full cost of services that are not covered 47
Please keep us up-to-date on any other health insurance coverage you have 47
Subrogation..... 48
What should you do if you have bills from non-plan providers that you think we should pay? 48

Paying the plan premium for your coverage as a member of First Seniority

To be a member of *First Seniority*, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member.

How much is your monthly plan premium and how do you pay it?

Premium bills for members enrolled through an employer will be sent directly to the employer unless employer group coverage ends. If you have any questions about your plan premiums, contact the Group Insurance Commission directly at (617) 727-2310 extension 801.

What happens if your employer group doesn't pay your plan premiums, or doesn't pay them on time?

Harvard Pilgrim may change your *First Seniority* status if your employer group does not pay your *First Seniority* premiums. Your membership through the employer group will be terminated and your *First Seniority* coverage changed to non-group status. As a non-group member, you will be responsible for the non-group premium. Harvard Pilgrim will notify you in writing of this change. If your plan premiums are past due, we will tell you in writing when a 90-day grace period begins. If you do not pay your past-due plan premiums within the 90-day grace period, we will disenroll you. Disenrolling you ends your membership in *First Seniority.* You will then have Original Medicare coverage (Section 12 explains about disenrollment and Original Medicare coverage). Should you decide later to re-enroll in *First Seniority*, or to enroll in another plan offered by Harvard Pilgrim, you will have to pay any past-due plan premiums that you still owe from your previous enrollment in *First Seniority*.

Paying your share of the cost when you get Covered Services

What are "Copayments"?

A **"Copayment"** is a payment you make for your share of the cost of certain Covered Services you receive. A Copayment is **a set amount per service** (such as paying $15 for *a doctor visit*). You pay it when you get the service. The Benefits Chart in Section 4 gives your Copayments for Covered Services. Section 4 and 6 gives your Copayments for prescription drugs.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by *First Seniority*. Other sections of this booklet tell about Covered Services and the rules that apply to getting your care as a plan member. With few exceptions, you must pay for services you receive from providers who are not part of *First Seniority* unless Harvard Pilgrim has approved these services in advance. The exceptions are care for a medical emergency, urgently needed care, out-of-area renal (kidney) dialysis services. (Sections 2 and 3 explain about using plan providers and the exceptions that apply.)

For Covered Services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service.** You can call Members Services when you want to know how much of your benefit limit you have already used.

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage besides *First Seniority*, it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is called "coordination of benefits" because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides *First Seniority*, and let us know whenever there are any *changes* in your additional insurance coverage. If you do not tell us about other insurance Harvard Pilgrim may not pay for Covered Services. The types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "Tricare for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

When you have additional insurance coverage, how we coordinate your benefits as a member of *First Seniority* with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through *First Seniority*, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by *First Seniority*, you may get your care outside of *First Seniority.*

In general, the insurance company that pays its share of your bills *first* is called the "**primary payer**." Then the other company or companies that are involved -- called the "**secondary payers**" -- each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second --or at all-- depends on what type or types of additional insurance you have and the rules that apply to your situation**. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance.

If you have additional health insurance, please call Member Services at the phone number located on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First.* You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov website.

Subrogation

Subrogation is a means by which Harvard Pilgrim and other health plans recover expenses of services where a third party is legally responsible for a Member's injury or illness.

If another person or entity is, or may be, liable to pay for services related to a Member's illness or injury which may have been paid for or provided by Harvard Pilgrim, Harvard Pilgrim will be subrogated and succeed to all rights of the member to recover against such person or entity 100% of the value of the services paid for or provided by Harvard Pilgrim. Harvard Pilgrim will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier or the Member's own auto insurance carrier in cases of uninsured or underinsured motorist coverage. In the event a Member has been reimbursed by another party for medical expenses provided or paid for by Harvard Pilgrim, Harvard Pilgrim shall be entitled to recover from such member 100% of the amount the Member has received for such services from Harvard Pilgrim.

To enforce its subrogation rights under this Benefit Handbook, Harvard Pilgrim will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by Harvard Pilgrim for which such party is, or may be liable.

Nothing in this Agreement shall be construed to limit Harvard Pilgrim's right to utilize any remedy provided by law to enforce its rights to subrogation under this Benefit Handbook.

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Sections 2 and 3, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the plan's service area, and care that has been approved in advance by Harvard Pilgrim. If a non-plan provider asks you to pay for Covered Services you get in these situations, please contact us at Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169. It is best to ask a non-plan provider to bill us first, but if you have already paid for the Covered Services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-plan provider any more than what he or she would have received from you if you had been covered with Original Medicare.

SECTION 9 Your rights and responsibilities as a member of *First Seniority*

Member Rights and Responsibilities 49
Introduction about your rights and protections 50
Your right to be treated with fairness and respect 50
Your right to the privacy of your medical records and personal health information 50
Your right to see plan providers and get Covered Services within a reasonable period of time 50
Your right to know your treatment choices and participate in decisions about your health care 51
Your right to use advance directives (such as a living will or a power of attorney) 51
Your right to make complaints 52
Your right to get information about your health care coverage and costs 52
Your right to get information about Harvard Pilgrim, *First Seniority*, and plan providers 52
How to get more information about your rights 52
What can you do if you think you have been treated unfairly or your rights are not being respected? 53
What are your responsibilities as a member of *First Seniority*? 53

Member Rights and Responsibilities

- Members have a right to receive information about Harvard Pilgrim, its services, its practitioners and providers, and members' rights and responsibilities.
- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to participate with practitioners in decision-making regarding their health care.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to voice complaints or appeals about Harvard Pilgrim or the care provided.
- Members have a right to make recommendations concerning Harvard Pilgrim's member rights and responsibilities policies.
- Members have a responsibility to provide, to the extent possible, information that Harvard Pilgrim and its practitioners and providers need in order to care for them.
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.
- Members have a responsibility to understand their health problems and participate, to the extent possible, in developing mutually agreed upon treatment goals.

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 9, we explain your Medicare rights and protections as a member of *First Seniority*. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048).

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Harvard Pilgrim must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Member Services at the number shown on the cover of this booklet. Member Services can also help if you need to file a complaint about access (such as wheel chair access).

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask *plan providers* to make additions or corrections to your medical records (if you ask *plan providers* to do this, *they* will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number on the cover of this booklet.

Your right to see plan providers and get Covered Services within a reasonable period of time

As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of *First Seniority*. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by *First Seniority*. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a plan provider has denied care that you believe you are entitled to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 11.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as SHINE (which stands for Serving Health Information Needs of Elders). Section 1 of this booklet tells how to contact SHINE. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the following agencies:

Against a hospital:

Department of Public Health
Division of Health Care Quality
Complaint Unit
10 West Street, Boston 02111-1212
Tel: (617) 753-8000

Against an individual doctor:

Board of Registration in Medicine
560 Harrison Ave., Suite G-4, Boston 02118
Tel: 1-800-377-0550

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals are discussed in Sections 10 and 11, and grievances are discussed in Section 10.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against Harvard Pilgrim in the past. To get this information, call Member Services at the phone number shown on the cover of this booklet.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay. If you need more information, please call Member Services at the number shown on the cover of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by *First Seniority*. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 10 and 11 for more information about filing an appeal.

Your right to get information about Harvard Pilgrim*, First Seniority, and plan providers*

You have the right to get information from us about Harvard Pilgrim and *First Seniority*. This includes information about our financial condition, about our health care providers and their qualifications, and about how *First Seniority* compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the phone number shown on the cover of this booklet.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at the number shown on the cover of this booklet. You can also get free help and information from Serving Health Information Needs of Elders, or SHINE (Section 1 tells how to contact SHINE). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections.* To get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Or you can visit the Medicare website at www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at 1-800-368-1019 (TTY: 1-800-537-7697).
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Member Services at the number shown on the cover of this booklet. You can also get help from Serving Health Information Needs of Elders, or SHINE (Section 1 tells how to contact SHINE).

What are your responsibilities as a member of First Seniority?

Along with the rights you have as a member of *First Seniority*, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the phone number shown on the cover of this booklet if you have any questions.
- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay any copayments you may owe for the Covered Services you get. You must also meet your other financial responsibilities that are described in Section 8 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number shown on the cover of this booklet.

SECTION 10 Appeals and grievances: what to do if you have complaints

Introduction 54
What are **appeals** and **grievances**? 54
This section tells how to make complaints in different situations 55
PART 1. Making complaints (called "appeals") to Harvard Pilgrim to change a decision about what we will cover for you or what we will pay for 55
PART 2. Making complaints if you think you are being discharged from the hospital too soon 57
PART 3. Making complaints if you think your coverage for SNF, home health or certified outpatient rehabilitation facility services is ending too soon. 59
PART 4. Making complaints (called "grievances") about any other type of problem you have with Harvard Pilgrim, *First Seniority* or one of our plan providers 60

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your Covered Services or the care you receive. Please call Member Services at the number listed on the cover of this booklet.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from *First Seniority* or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make.

- An "appeal" is the type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If Harvard Pilgrim or one of our plan providers refuses to give you a service you think should be covered, you can file an appeal. If Harvard Pilgrim or one of our plan providers reduces or cuts back on services you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service too soon, you can file an appeal.

- A "grievance" is the type of complaint you make if you have any other type of problem with Harvard Pilgrim, *First Seniority* or one of our plan providers. For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

1. **Making complaints (called "appeals") about what we will cover for you or what we will pay for.** If Harvard Pilgrim or your doctor or another plan provider has refused to give you a service you think is covered, you can make an appeal. If we have refused to pay for a service you think is covered for you, you can make an appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).

2. **Making complaints (called "appeals") if you think you are being discharged from the hospital too soon**. There is a special type of appeal that applies only to hospital discharges. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to MASSPRO, which is the Quality Improvement Organization (QIO) in the state of Massachusetts. The QIO is a group of health professionals *in your state* that is paid to handle this type of appeal from Medicare patients. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

3. **Making complaints (called "appeals") if you think your coverage for SNF, home health or certified outpatient rehabilitation facility services is ending too soon.** There is another special type of appeal that applies only to when coverage will end for SNF, home health or certified outpatient rehabilitation facility services. If you think your coverage is ending too soon, you can appeal directly and immediately to MASSPRO, which is the Quality Improvement Organization in the state of Massachusetts. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

4. **Making complaints (called "grievances") about any other type of problem you have with Harvard Pilgrim/*First Seniority* or one of our plan providers**. If you want to make a complaint about any type of problem other than the two that are listed above, a grievance is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. Generally, you would file the grievance with Harvard Pilgrim. But for many problems related to quality of care you get from plan providers, you can also complain to the QIO in your state.

PART 1. Making complaints (called "appeals") to Harvard Pilgrim to change a decision about what we will cover for you or what we will pay for

This part of Section 10 explains what you can do if you have problems getting the medical care you believe we should provide. We use the word "provide" in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by *First Seniority.*
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by *First Seniority*.

- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by *First Seniority* while you were a member, but we have refused to pay for this care.

Six possible steps for requesting care or payment from *First Seniority*

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The six possible steps are summarized below (they are covered in more detail in Section 11).

STEP 1: The initial decision by Harvard Pilgrim

The starting point is when we make an "initial decision" (also called an "organization determination") about your medical care or about paying for care you have already received. When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of *First Seniority* apply to your specific situation. As explained in Section 11, you can ask for a "fast initial decision" if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by Harvard Pilgrim

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**appeal**" or a "request for reconsideration." As explained in Section 11, you can ask for a "fast appeal" if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of Harvard Pilgrim. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least $100 to be considered in Step 4.

STEP 5: Review by a Departmental Appeals Board

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a **Departmental Appeals Board** to review your case**.** This Board is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the Departmental Appeals Board in Step 5, either of us may be able to take your case to a Federal Court. The dollar value of your contested medical care must be at least $1,000 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, see Section 11.

PART 2. Making complaints if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by *First Seniority* that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer medically necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.

Review of your hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, you must ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights.* This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do it you think you are being discharged too soon.
- Who to contact for help.

You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, be sure to ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Harvard Pilgrim or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Massachusetts, the QIO is called MASSPRO. The doctors and other health experts in MASSPRO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of whether you are ready to leave the hospital. This "fast review" is also called a "fast appeal" because you are appealing the discharge date that has been set for you.
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the QIO gives you its decision.
- If the QIO agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking Harvard Pilgrim *for a "fast appeal" of your discharge*

If you do not ask the QIO for a "fast review" ("fast appeal") of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, then we will not cover any hospital care you received if you stayed in the hospital after the discharge date.

You may have to pay if you stay past your discharge date

If you do not ask the QIO by noon of the next working day after you are given written notice that you are being discharged from the hospital, and if you stay in the hospital after this date, you run the risk of having to pay for the hospital care you receive on and after this date. However, you can appeal any bills for hospital care you receive, using Step 1 of the appeals process described in Section 11.

PART 3. Making complaints if you think your coverage for SNF, home health or certified outpatient rehabilitation facility services is ending too soon.

When you are a patient in a SNF, home health agency, or certified outpatient rehabilitation facility (CORF), you have the right to get all the SNF, home health or CORF care covered by *First Seniority* that is necessary to diagnose and treat your illness or injury. The day we end your SNF, home health agency or CORF coverage is based on when your stay is no longer medically necessary. This part of Section 10 explains what to do if you believe that your coverage is ending too soon.

Information you should receive during your SNF, home health agency or CORF stay

If we decide to end our coverage for your SNF, home health agency, or CORF services, you will get written notice from your provider at least 2 calendar days in advance of our ending our coverage. You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

Review of the termination of your coverage by the Quality Improvement Organization

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from your provider, you can ask the Quality Improvement Organization (the "QIO") to review whether our terminating your coverage is medically appropriate.

Getting a QIO review of your coverage

If you want to have the termination of your coverage appealed, you must act quickly to contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the notice from your provider.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request **no later than noon** the day before the date that your Medicare coverage ends.

If the QIO reviews your case, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

- If the QIO decides that the decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, home health or CORF charges after the termination date on the advance notice you got from your provider.
- If the QIO agrees with you, then we will continue to cover your SNF, home health or CORF services for as long as medically necessary.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking Harvard Pilgrim for a "fast appeal" of your discharge

If you do not ask the QIO for a "fast appeal" of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, home health agency, or CORF, you run the risk of having to pay for the care you receive past your termination date.

Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will **not** cover any of the care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date

If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, home health or CORF services, and if you stay in the SNF, home health agency or CORF after this date, you run the risk of having to pay for the SNF, home health or CORF care you receive on and after this date. However, you can appeal any bills for SNF, home health or CORF care you receive using Step 1 of the appeals process described in Section 11.

PART 4. Making complaints (called "grievances") about any other type of problem you have with Harvard Pilgrim, *First Seniority* or one of our plan providers

This last part of Section 10 explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to coverage or payment for care, and problems about being discharged from the hospital too soon.)

What is included in "all other types of problems"?

Here are some examples of problems that are included in this category of "all other types of problems":

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you disagree with our decision to not give you a "fast appeal," or if we take an extension on our initial decision or appeal (initial decisions, appeals, and extensions for initial decisions and appeals are described in Section 11). In these cases, you have the right to ask for a "fast grievance."
- If you feel that you are being encouraged to leave (disenroll from) *First Seniority*.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Filing a grievance with *First Seniority*

If you have a complaint, we encourage you to first call Member Services at the number shown on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Harvard Pilgrim grievance procedure. To use the formal grievance procedure, send your grievance in writing to Member Services. We will write you to let you know how we have addressed your concern within 30 business days after we get your written grievance. In some instances we will need additional time to address your concern. If additional time is needed, we will keep you informed of how your grievance is being handled. Whether you use the formal (written) or informal (telephone) grievance procedure, we must keep track of all appeals and grievances in order to report data to CMS and to our Members, upon request.

For quality of care problems, you may also complain to the QIO

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the QIO. See Section 1 for more information about the QIO.

SECTION 11 Detailed information about how to make an appeal

What is the purpose of this section? 62
What are "complaints about your coverage or payment for your care"? 62
How does the appeals process work? 63
STEP 1: Harvard Pilgrim makes an "initial decision" about your medical care, or about paying for care you have already received 63
STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an "appeal" or "request for reconsideration." 66
STEP 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization 68
STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge 70
STEP 5: Your case may be reviewed by a Departmental Appeals Board 70
STEP 6: Your case may go to a Federal Court 70

What is the purpose of this section?

The purpose of this section is to give you more information about a topic that is summarized briefly in the previous section of this booklet (Section 10). Section 10 outlines the six possible steps in the appeals process for making complaints about your coverage or payment for your care. This section goes through the same six steps in more detail. Since Section 10 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, **you should read Section 10 before you read this section.**

A note about terminology. In this Section, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process. For example, we generally say "initial decision" instead of "initial organization determination," and we generally use the word "fast" rather than "expedited" when referring to decisions that are made more quickly than the standard time frame. Instead of saying "adverse decision," we may say "deny your request," or "turn down your appeal." We use "independent review organization" rather than "independent review entity."

What are "complaints about your coverage or payment for your care"?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a plan member. This includes payment for care received while a member of *First Seniority*. Complaints about your coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by *First Seniority*
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by *First Seniority*
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health
- If you have received care that you believe is covered by *First Seniority*, but we have refused to pay for this care because we say it is not covered

How does the appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one step to the next**. At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.

- **"Initial decision" vs. "making an appeal."** Step 1 deals with the starting point for the appeals process. The decision made in Step 1 is called an "initial decision" or "organization determination." If you continue with your complaint by going on to Step 2, it is called making an "appeal" or a "request for reconsideration" of our initial decision because you are "appealing" for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involve *appealing* a decision.

- **Who makes the decision at each step**. In Step 1, you make your request for coverage of care or payment for care directly to us. We review this request, then make an initial decision. If our initial decision turns down your request, you can go on to Step 2, where you "appeal" this initial decision (asking us to reconsider). **After Step 2, your appeal goes outside of Harvard Pilgrim, where people who are not connected to us conduct the review and make the decision.** To help ensure a fair, impartial decision, those who make the decision about your appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

STEP 1: Harvard Pilgrim makes an *"initial decision"* about your medical care, or about paying for care you have already received

What is an "initial decision"?

The "initial decision" made by Harvard Pilgrim is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This "initial decision" is sometimes called an "organization determination.") If our initial decision is to deny your request (this is sometimes called an "adverse initial decision"), you can "appeal" the decision by going on to Step 2 (see below). You may also go on to Step 2 if we fail to make a timely "initial decision" on your request.

- If you ask us to pay for medical care you have already received, this is a request for an "initial decision" about payment for your care. You can call us at **1-800-421-3550** to get help in making this request.

- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an "initial decision" about whether the treatment you want is covered by *First Seniority*. Depending on the situation, your doctor or other medical provider may make this decision on behalf of Harvard Pilgrim, or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to ask for an initial decision.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of *First Seniority* apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by *First Seniority*, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by *First Seniority*).

Who may ask for an "initial decision" about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169. You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to learn how to name your authorized representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact Medicare Advocacy Project at 1-800-323-3205 (for TTY call 1-617-371-1228).

"Standard decisions" vs. "fast decisions" about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is sometimes called a 72-hour decision or an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: Harvard Pilgrim, 1600 Crown Colony Drive, Quincy, MA 02169.

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at **1-800-421-3550** (for TTY, call **1-800-421-3599**). Or, you can deliver a written request to Harvard Pilgrim, 1600 Crown Colony Drive, Quincy, MA 02169, or fax it to 1-617-509-3086. Be sure to ask for a "fast" or "72-hour" review.

- If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor's support for a "fast" review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an "initial decision"?

What happens, including how soon we must decide depends on the type of decision.

1. For a decision about payment for care you already received.

We have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. (An appeal is also called a reconsideration.) Step 2 tells how to file this appeal.

2. For a <u>standard</u> initial decision about medical care.

We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a "grievance." Section 10 of this booklet tells how to file a grievance.

We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. Step 2 tells how to file this appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you do have the right to appeal.

3. For a <u>fast</u> initial decision about medical care.

If you receive a "fast" review, we will give you our decision about your medical care within 72 hours after you or your doctor ask for a "fast" review -- sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a "grievance." Section 10 of this booklet tells how to file a grievance.

We will tell you our decision by phone as soon as we make the decision. Within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a grievance. Section 10 of this booklet tells how to file a grievance.

What happens next if we decide completely in your favor?

If we make an "initial decision" that is completely in your favor, what happens next depends on the situation.

1. For a decision about payment for care you already received.

We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

2. For a <u>standard</u> decision about medical care.

We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

3. For a <u>fast</u> decision about medical care.

We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you *all* that you requested, you have the right to ask us to reconsider the decision. (See Step 2).

STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an *"<u>appeal</u>"* or *"request for reconsideration."*

Please call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) if you need help in filing your appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* are the same as those described for a "standard" or "fast" *initial decision* in Step 1. Please see the discussion in Step 1 under "Do you have a request for medical care that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision."

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Harvard Pilgrim, 1600 Crown Colony Drive, Quincy MA 02169.
- By fax, at 1-617-509-3086.
- By telephone -- if it is a "fast" appeal -- at **1-800-421-3550**.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at **1-800-421-3550**, (for TTY call **1-800-421-3599**); Harvard Pilgrim, 1600 Crown Colony Drive, Quincy MA 02169.

How do you file your appeal of the initial decision?

The rules about who may file an appeal in Step 2 are the same as the rules about who may ask for an "initial decision" in Step 1. Follow the instructions in Step 1 under "Who may ask for an 'initial decision'" about medical care or payment?"

Either you, someone you appoint, or your provider may file this appeal.

However, providers who do not have a contract with Harvard Pilgrim must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

The appeal should be given to us in writing at Harvard Pilgrim, 1600 Crown Colony Drive, Quincy MA 02169, within 60 calendar days after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

You may also send your appeal to your Social Security Administration office or, if you are a railroad retiree, to a Railroad Retirement Board office. Please note that sending your appeal to either of these offices instead of to us will cause a delay when we begin the appeal, since these offices must forward your appeal request to us.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal in Step 2 are the same as the rules about asking for a "fast" initial decision in Step 1. If you want to ask for a "fast" appeal in Step 2, please follow the instructions in Step 1 under "Asking for a fast decision."

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a decision about payment for care you already received.*

After we receive your appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal *automatically* goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

After we receive your appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

3. *For a fast decision about medical care.*

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received.*

   We must pay within 60-calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your appeal automatically goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

   We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

   We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal -- or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal in Step 2, then your appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of Harvard Pilgrim. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the independent review organization that performs the review in Step 3 depends on the type of appeal:

1. *For a decision about payment for care you already received.*

   We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your appeal in Step 2.

2. *For a standard decision about medical care.*

   We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal in Step 2.

3. *For a fast decision about medical care.*

   We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

STEP 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization

What independent review organization does this review?

In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For an appeal about payment for care,* the independent review organization has up to 60 calendar days to make a decision.

2. *For a standard appeal about medical care,* the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

3. *For a fast appeal about medical care,* the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For an appeal about payment for care,* we must pay within 30 calendar days after receiving the decision.

2. *For a standard appeal about medical care,* we must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.

3. *For a fast appeal about medical care,* we must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your appeal is $100 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You have a choice about where you send your written request:

- Directly to the independent review organization that reviewed your appeal in Step 3. They will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

- To Harvard Pilgrim, or to your local Social Security Administration office. If you do this, starting Step 4 will take longer because your request must first be forwarded to the independent review organization that reviewed your appeal in Step 3. The independent review organization will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your appeal for a review by an Administrative Law Judge. During this review, you may present evidence, review the record, and be represented by council. The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than $100. If the dollar value is less than $100, you may not appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Departmental Appeals Board (Step 5).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Departmental Appeals Board (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

STEP 5: Your case may be reviewed by a Departmental Appeals Board

This Board will first decide whether to review your case

The Departmental Appeals Board does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or Harvard Pilgrim may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is $1,000 or more. If the dollar value is less than $1,000, you may not appeal any further.

How soon will the Board make a decision?

If the Departmental Appeals Board reviews your case, they will make their decision as soon as possible.

If the Board decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least $1,000. If the dollar value is less than $1,000, the Board's decision is final.

If the Board decides against you

If the amount involved is $1,000 or more, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than $1,000, you may not take the appeal any further.

STEP 6: Your case may go to a Federal Court

If the contested amount is $1,000 or more, you or we may ask a Federal Court Judge to review the case.

SECTION 12 Leaving *First Seniority* and your choices for continuing Medicare after you leave

What is "**Disenrollment**"? 71
Until your membership officially ends, you must keep getting your Medicare services through *First Seniority* or you will have to pay for them yourself 71
What are your choices for continuing Medicare if you leave *First Seniority*? 72
When can you change your Medicare choices? 72
What should you do if you decide to leave *First Seniority*? 73
What happens to you if Harvard Pilgrim leaves the Medicare program or *First Seniority* leaves the area where you live? 74
You must leave *First Seniority* if you move out of the service area or are away from the service area for more than six months in a row 75
Under certain conditions Harvard Pilgrim can end your membership and make you leave the plan 75

What is "Disenrollment"?

"Disenrollment" from *First Seniority* means **ending your membership** in *First Seniority*. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave *First Seniority* because you have decided that you *want* to leave. You can do this for any reason. In such an event, you should contact the Group Insurance Commission directly at (617) 727-2310 extension 801.
- There are also a few situations where you would be *required* to leave. For example, you would have to leave *First Seniority* if you move out of our geographic service area or if *First Seniority* leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership officially ends, you must keep getting your Medicare services through First Seniority or you will have to pay for them yourself

If you leave *First Seniority*, it takes some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through *First Seniority*. If you get services from doctors or other medical providers who are **not** plan providers before your membership in *First Seniority* ends, neither Harvard Pilgrim nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Member Services at the number on the cover of this booklet to find out if your hospital care will be covered by *First Seniority*. If you have any questions about leaving *First Seniority*, please call us at Member Services.

What are your choices for continuing Medicare if you leave First Seniority?

If you leave *First Seniority*, you should contact the Group Insurance Commission to find out all the options that are available to you. One choice for continuing with Medicare is to go to **Original Medicare.** You may also have the choice of joining another **Medicare managed care plan** or a **Medicare Private Fee-for-Service plan** *if* any of these types of plans are available in your area and they are accepting new members.

- **Original Medicare** is available throughout the country. It is a pay-per-visit or "fee-for-service" health plan that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). Original Medicare is the way most people get their Medicare Part A and Part B health care.

- **Medicare Managed Care Plans** (such as HMOs or PPOs) are available in some parts of the country. In HMOs you go to the doctors, hospitals, and other providers *that are part of the plan*. In PPOs, you can usually see any doctor but you may pay more to see doctors, hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. *First Seniority* is a Medicare managed care plan offered by Harvard Pilgrim.

- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* Medicare-approved doctor or hospital that accepts the plan's payment The Private Fee-for-Service plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover. Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance) policies.

When can you change your Medicare choices?

All through the year, everyone with Medicare (including members of *First Seniority*) is allowed to change from their current way of getting Medicare to one of their other choices. As we have explained above, you have one or more of the following choices about how you get your Medicare coverage. They are:

- **Original Medicare**. This choice is available to you throughout the year.

- A **Medicare Managed Care Plan.** This choice is available to you **if** there are Medicare managed care plans in your area, and **if** they are accepting new members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare+Choice plans must accept new members (unless unusual circumstances apply).

- A **Medicare Private Fee-for-Service plan.** This choice is available to you **if** there are Medicare Private Fee-for-Service plans in your area, and **if** they are accepting new members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Private Fee-for-Service plans must accept new members (unless unusual circumstances apply).

In most cases, your disenrollment date will be the first day of the month that comes *after* the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: if we receive your request between November 15 and 30, the change will take effect on January 1, unless you specifically ask for a disenrollment date of December 1.

What should you do if you decide to leave First Seniority?

- First, contact the Group Insurance Commission to find out what your options are.
- Then, as explained below, what you must do to leave First Seniority depends on whether you want to switch to Original Medicare or to one of your other choices.

How to change from *First Seniority* to Original Medicare

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from *First Seniority* to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact Serving Health Information Needs of Elders (SHINE). The phone number is in Section 1. You can ask SHINE about how and when to buy a Medigap policy if you need one. SHINE can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you have a "**guaranteed issue right,**" this means that the Medigap insurer must sell you a Medigap policy, even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a Medicare managed care plan "trial period" and you change to Original Medicare. Generally, a Medicare managed care plan trial period begins on the date of "first time" enrollment in a Medicare health plan (other than Original Medicare) and ends 12 months later. You may be in a Medicare managed care plan trial period if in the past 12 months you: (1) dropped a Medigap policy to join a Medicare health plan for the first time; or (2) joined a Medicare health plan upon first becoming entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. SHINE can tell you about other situations where you may have guaranteed issue rights.

If you do buy a Medigap policy, you still have to follow the instructions below for changing from *First Seniority* to Original Medicare. (Buying a Medigap policy does not switch you from *First Seniority* to Original Medicare. A Medigap sales person or insurance agent cannot cancel your *First Seniority* membership and put you in Original Medicare.)

How to change from First Seniority to Original Medicare

First, contact the Group Insurance Commission to find out what your options are. If you decide to change from *First Seniority* to Original Medicare, you must tell us (or one of the offices listed below) that you want to leave *First Seniority*. You do *not* have to notify Original Medicare, because you will automatically be in Original Medicare when you leave *First Seniority*. Here is how it works:

1. First, use any of the following ways to tell us that you want to leave *First Seniority*:
   - You can write or fax a letter to us or fill out a disenrollment form and send it to *First Seniority* Enrollment and Billing at P.O. Box 690386, Quincy, MA 02269-0386. Be sure to sign and date your letter or *form*. To get a disenrollment form, call us at the Member Services telephone number shown on the cover of this booklet.
   - You can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048.
   - You can contact your nearest Social Security office or, if you have Railroad Retirement benefits, you can contact the Railroad Retirement Board office. Section 1 tells you how to contact these offices.
2. We will then send you a letter that tells you when your membership will end. This is your **disenrollment**

date – the day you officially leave *First Seniority*. In most cases, your disenrollment date will be the first day of the month that comes after the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: the disenrollment date for requests received between November 15 and November 30 are effective on January 1, unless you specifically ask us to disenroll you on December 1. Remember, while you are waiting for your membership to end, you are still a member of *First Seniority* and must continue to get your medical care as usual through *First Seniority*.

3. On your disenrollment date, your membership in *First Seniority* ends, and you can start using your red, white, and blue Medicare card to get services under Original Medicare**.** You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave *First Seniority*. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

How to change from *First Seniority* to *another* Medicare managed care plan or to *another* Private Fee-for-Service Plan

First, contact the Group Insurance Commission to find out what your options are. If you want to change from *First Seniority* to a *different* Medicare managed care plan or to a *different* Private Fee-for-Service plan, here is what to do:

1. Contact the plan you want to join to be sure it is accepting new members.

2. If the plan is accepting new members, apply for membership in the plan. **Once you are enrolled in your new plan, your membership in *First Seniority* will *automatically* end**. This means that you do not need to tell us that you are leaving. However, we do encourage you to tell us why you left.

3. Your new plan will tell you in writing the date when your membership in that plan begins, and your membership in *First Seniority* will end on that same day (this will be your "disenrollment date"). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through *First Seniority* until the date your membership ends.

What happens to you if Harvard Pilgrim leaves the Medicare program or First Seniority leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in *First Seniority* will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through *First Seniority* until your membership ends.

In such an event, you should contact the Group Insurance Commission directly. Your choices will always include Original Medicare. Your choices may also include joining *another* Harvard Pilgrim *plan*, *another* Medicare managed care plan, or *another* Private Fee-for-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you may change to another way of getting your Medicare benefits at any time. If you decide to change from *First Seniority* to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a "guaranteed issue right" and it is explained earlier in this section under the heading, "Do you need to buy a Medigap (Medicare supplement insurance) policy?"

Harvard Pilgrim has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Harvard Pilgrim or CMS can decide to end it. It is also possible for our contract to end at some other time, too. You will get 90 days advance notice in this situation. If the contract is going to end, we will generally tell you 90 days in advance. Your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

You must leave First Seniority if you move out of the service area or are away from the service area for more than six months in a row

If you plan to move or take a long trip, please call Member Services at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in plan's service area. If you move permanently out of our service area, or if you are away from our service area for more than six months in a row, you will need to leave ("disenroll" from) *First Seniority*. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). An earlier part of this section tells about the choices you have if you leave *First Seniority* and explains how to leave.

Under certain conditions Harvard Pilgrim can end your membership and make you leave the plan

We *cannot* ask you to leave the plan because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave *First Seniority* because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line.

We *can* ask you to leave the plan under certain special conditions

If any of the following situations occur, we will need to end your membership in Harvard Pilgrim.

- If you move out of our geographic service area or live outside the plan's service area for more than six months at a time (see Section 2 for information about the plan's service area).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 8 for information about staying enrolled in Part A and Part B).
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in *First Seniority*.
- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange or provide medical care for you or for others who are members of *First Seniority*. We cannot make you leave *First Seniority* for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. Before we ask you to leave *First Seniority* for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.
- If you do not pay the plan premiums, we will tell you that you have a 90-day grace period during which you can pay the plan premiums before you are required to leave *First Seniority*.

You have the right to make a complaint if we ask you to leave Harvard Pilgrim

If we ask you to leave *First Seniority*, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

SECTION 13 Legal Notices

Notice about governing law 76
Notice about non-discrimination 76
Access to Information 76
Confidentiality 77
Evaluation of New Technology 77
Member Notices (Mailing Address) 78
Modification of This Benefit Handbook 78
Relationship of *First Seniority* Providers and Harvard Pilgrim 78
Benefits in The Event of Other Insurance 78
Workers' Compensation/Government Programs 78
Medical Payment Policies 78
Member Cooperation 79
Harvard Pilgrim's Rights 79

Notice about governing law

Many different laws apply to this Benefit Handbook. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State(s) of Massachusetts may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare managed care plans, like Harvard Pilgrim, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Access to Information

The Member agrees that, except where restricted by law, Harvard Pilgrim may have access to (a) all health record and medical data from health care providers covered under this Benefit Handbook and (b) information concerning health coverage or claims from all providers of motor vehicle insurance, medical payment policies, home owners insurance and all types of health benefit plans that pertains to services you receive while a member of *First Seniority*. Harvard Pilgrim will comply with all laws restricting access to special types of medical information, including, but not limited to, HIV test data, drug and alcohol abuse rehabilitation record and mental health services.

Confidentiality

Harvard Pilgrim is committed to ensuring and safeguarding the confidentiality of its members' personal and medical information in all settings. Harvard Pilgrim staff access, use and disclose members' personal information only in connection with providing services and benefits and in accordance with Harvard Pilgrim's confidentiality policies. Harvard Pilgrim permits only designated employees, who are trained in the proper handling of member information, to have access to and use of your information. Harvard Pilgrim sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to Harvard Pilgrim's confidentiality and privacy standards.

When you enrolled with Harvard Pilgrim, you consented to disclosures which are necessary for the provision and administration of services and benefits, such as: coordination of care, including referrals and authorizations; conducting quality activities, including member satisfaction surveys and disease management programs; verifying eligibility: fraud detection and certain oversight reviews, such as accreditation. When Harvard Pilgrim uses or discloses your personal information, it does so using the minimum amount of information necessary to accomplish the specific activity.

Harvard Pilgrim discloses its members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your Benefit Handbook. Whenever possible, Harvard Pilgrim discloses member information without member identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. Harvard Pilgrim will not disclose to other third parties, such as employers, member-specific information (i.e. information from which you are personally identifiable) without your specific consent unless permitted by law or as necessary to accomplish the types of activities described above.

Harvard Pilgrim and all of its contacted health care providers agree to provide members' access to, and a copy of, their medical records upon a member's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

If you have any questions about the Harvard Pilgrim confidentiality policies you may contact the *First Seniority* Member Services Department at **1-800-421-3550**. Hours of operation are 8:00 a.m. to 7:30 p.m. on Monday and Wednesday and 8:00 a.m. to 5:30 p.m. on Tuesday, Thursday and Friday. A Member Services representative will be happy to assist you. If you are hearing impaired, please call **1-800-421-3599** for TTY service.

Evaluation of New Technology

The Plan covers medical devices; diagnostic, medical and surgical procedures and drugs as described in your Benefit Handbook, Schedule of Benefits, and if applicable, your Prescription Drug Brochure. This includes new devices, procedures and drugs, as well as those with new applications, as long as they are not Experimental or Unproven.

Harvard Pilgrim has a specialized team that evaluates diagnostics, medical therapies, surgical procedures, medical devices and drugs. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation. The team researches the safety and effectiveness of these new technologies by reviewing published medical reports, literature, expert consultation with practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan.*

*For *First Seniority* Members, Medicare Covered Services are determined per Medicare coverage guidelines and local medical review policies.

Member Notices (Mailing Address)

Any notice to a Member may be sent to the last address of the Member on file with Harvard Pilgrim. Notice of a change of address should be sent to Harvard Pilgrim at the address listed on page 1 of this Benefit Handbook.

Modification of This Benefit Handbook

This Benefit Handbook and the Enrollment Form comprise the entire contract between you and Harvard Pilgrim. It can only be modified in writing by an authorized officer of Harvard Pilgrim with approval from CMS. No other action by Harvard Pilgrim, including the deliberate non-enforcement of any benefit limit, shall be deemed to waive or alter any part of this Benefit Handbook. Changes can be made on an annual basis. Changes made during the year can only result in an increase of benefits or decrease in copays for you and must be approved in advance by CMS.

Relationship of First Seniority Providers and Harvard Pilgrim

The relationship of Harvard Pilgrim to providers, other than Harvard Pilgrim employees, is governed by separate agreements. They are independent contractors. Such providers may not modify this Benefit Handbook or create any obligation for Harvard Pilgrim. Harvard Pilgrim is not liable for statements about this Benefit Handbook by them, their employees or agents.

Benefits in The Event of Other Insurance

Payments for Harvard Pilgrim benefits under this Benefit Handbook will be coordinated with benefits available under the Member's other insurance policies, including but not limited to motor vehicle insurance, medical payment policies, home owners insurance, health insurance and self-insured health benefits programs. One plan shall have primary obligation for services; the other plan(s) shall have secondary obligation. No duplication shall occur in payment for or rendering of services. Medicare requirements will control.

Workers' Compensation/Government Programs

If Harvard Pilgrim has information indicating that services provided to a Member are covered under Workers' Compensation, employer's liability or other program of similar purpose or by a federal, state or other government agency, Harvard Pilgrim may suspend payment for such services until a determination is made whether payment will be made by such program.

If Harvard Pilgrim provides or pays for services for an illness or injury covered under Workers' Compensation, employer's liability or other program of similar purpose or by a federal, state or other government agency, Harvard Pilgrim will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

Medical Payment Policies

For Members who are entitled to benefits under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, such coverage shall become primary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy. The benefits under this Benefit Handbook shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this Benefit Handbook to Members that are covered under any medical payment policy or benefit are payable by Harvard Pilgrim.

Member Cooperation

The Member agrees to cooperate with Harvard Pilgrim in exercising its rights of subrogation and coordination of benefits under this Benefit Handbook. Such cooperation will include, but not be limited to: a) the provision of all information and documents requested by Harvard Pilgrim; b) the execution of any instruments deemed necessary by Harvard Pilgrim to protect its rights; c) the prompt assignment to Harvard Pilgrim of any monies received for services provided or paid for by Harvard Pilgrim and d) the prompt notification to Harvard Pilgrim of any instances that may give rise to Harvard Pilgrim's rights. The Member further agrees to do nothing to prejudice or interfere with Harvard Pilgrim's rights to subrogation or coordination of benefits.

Harvard Pilgrim's Rights

Nothing in this Benefit Handbook shall be construed to limit Harvard Pilgrim's right to utilize any remedy provided by law to enforce its rights to subrogation or coordination of benefits under this Benefit Handbook.

SECTION 14 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Acute Hospital – Any hospital other than a Long Term Hospital, a Rehabilitation Hospital or a Psychiatric Hospital.

Appeal – Any of the procedures that deal with the review of adverse initial decisions on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include reconsiderations by Harvard Pilgrim, review by an independent outside organization, hearings before Administrative Law Judges (of the Social Security Administration), review by the Departmental Appeals Board, and judicial review. Sections 10 and 11 explain about appeals, including the process involved in making an appeal.

Benefit period – For both *First Seniority* and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period *ends* when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

- You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 7 tells what is meant by skilled care.)
- Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Calendar Year – The period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Centers for Medicare & Medicaid Services (CMS) – The Federal Agency that runs the Medicare program (CMS was formerly known as the Health Care Financing Administration). Section 1 tells how you can contact CMS.

Copayment – A Copayment is a dollar amount that is payable by the Member for certain covered services. The Copayment is due at the time the service is received or when billed by the provider.

Covered Services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by *First Seniority*. Covered Services are listed in the Benefits Chart in Section 4.

Custodial Care – Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by *First Seniority* or Original Medicare unless provided with skilled nursing care and/or skilled rehabilitation services.

Disenroll or disenrollment – The process of ending your membership in *First Seniority*. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 12 tells about disenrollment.

Durable Medical Equipment – is equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Emergency Medical Condition – A medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in 1) Serious jeopardy to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child); 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency care – Covered Services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Evidence of Coverage and Disclosure Information (also known as the Benefit Handbook) – This document, along with your enrollment form explains the Covered Services, defines our obligations, and explains your rights and responsibilities as a member of the *First Seniority*.

Exclusion – Items or services that *First Seniority* does not cover. You are responsible for paying for excluded items or services.

Experimental Procedures and Items – Items and procedures determined by Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, Harvard Pilgrim will follow the Centers for Medicare & Medicaid Services' manuals or will follow decisions already made by Medicare. With the exception of procedures and items under approved clinical trials, experimental procedures and items are not covered under this Benefit Handbook.

Grievance – Any complaint or dispute other than one involving an "initial decision." Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeal process include: waiting times in physician offices and rude or unresponsive Member Service staff. Section 10 explains about grievances.

Home Health Agency – A Medicare-certified agency that provides skilled nursing care and other therapeutic services in your home when medically necessary.

Hospice – A Medicare-certified organization or agency that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital – A Medicare-certified institution licensed by the State, that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "hospital" does not include a convalescent nursing home, rest facility or facility for the aged that primarily provides custodial care, including training in routines of daily living.

Hospital Day - Any day of a Benefit Period during which *First Seniority* or Original Medicare covered your inpatient care in an Acute, Rehabilitation, Long Term or Psychiatric Hospital, excluding the day of discharge.

Hospitalist – A physician who specializes in treating patients when they are in the hospital and who may coordinate a patient's care when he or she is admitted at a *First Seniority* hospital.

Independent Practice Association (IPA) – A partnership, association, or corporation that delivers or arranges for the delivery of health services and which has entered into a contract with health professionals, a majority of whom are licensed to practice medicine or osteopathy.

Initial decision – In general, a decision by Harvard Pilgrim, or a person acting on Harvard Pilgrim's behalf, to approve or deny a payment for a service or a request for provision of service made by you or on your behalf.

Lock-In – An arrangement under which all Covered Services, except emergency services, urgently needed services, or out-of-area renal dialysis services, must be provided or authorized by your plan provider or your PCP. If you get any other services from a non-plan provider or a plan provider such as a specialist without prior authorization, neither Harvard Pilgrim nor Original Medicare will pay for that care. (There are very limited exceptions to this rule, including the right to self-refer for Flu Shots and Mammography Screening services. See the Schedule of Medical Benefits in Section 5 for specific limitations that apply to self-referral for these benefits).

Long Term Hospital – A Long Term Hospital (sometimes called a "Chronic Hospital") is a hospital authorized to care for Medicare beneficiaries that specialize in caring for patients on a long-term basis. For the purpose of this Benefit Handbook, a hospital will be considered a Long Term Hospital if it is classified as a Long Term Hospital under Medicare Regulations (42 CFR Section 412.23). Long Term Hospitals have an average inpatient length of stay greater than 25 days and serve patients that often require services that cannot be provided in most Skilled Nursing Facilities.

Medical Director – A licensed physician who is responsible for the overall quality of the medical care we provide.

Medically necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare+Choice Organization – A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide Covered Services. Medicare+Choice Organizations can offer one or more Medicare+Choice Plans. Harvard Pilgrim is a Medicare+Choice Organization.

Medicare+Choice Plan – A benefit package offered by a Medicare+Choice Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare+Choice Organization may offer more than one plan in the same service area. *First Seniority* is a Medicare+Choice Plan.

Medicare Cost Plan – A specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all people with Medicare living in the service area covered by the Plan. A company offering a Cost Plan may offer more than one plan in the same service area. Members under this plan may use Original Medicare benefits from any Medicare provider.

"Medigap" (Medicare supplement insurance) policy – Many people who get their Medicare through Original Medicare buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

Member (member of *First Seniority*, or "plan member") – A person with Medicare who is eligible to get Covered Services, who has enrolled in *First Seniority*, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member services – A department within Harvard Pilgrim responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services. A *First Seniority* Member Services representative is available to assist you during regular business hours by calling **1-800-421-3550**, TTY/TDD: **1-800-421-3599**, (Hours of operation are 8:00 a.m. - 7:30 p.m. on Monday and Wednesday, and 8:00 a.m. - 5:30 p.m. on Tuesday, Thursday and Friday.)

Network – A group of health care providers under contract with Harvard Pilgrim that is licensed and/or certified by Medicare with the purpose of delivering or furnishing health care services. Generally, Member must receive routine services within their designated network in order to be covered by Harvard Pilgrim.

Non-Plan Provider or Non-Plan Facility – A provider or facility that we have **not** arranged with to coordinate or provide Covered Services to members of *First Seniority*. Non-plan providers are providers that are not employed, owned, or operated by Harvard Pilgrim and are not under contract to deliver Covered Services to you. As explained in this booklet, most services you get from non-plan providers are not covered by Harvard Pilgrim or Original Medicare.

Office Visit – A visit for Covered Services to your PCP, specialist, other plan provider or non-plan provider upon referral.

Optional benefits – Non-Medicare covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional benefits, you may have to pay an additional premium. Members of *First Seniority* must voluntarily elect Optional Benefits in order to get them.

Original Medicare – A plan that is available everywhere in the United States. Some people call it "traditional Medicare" or "fee-for-service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Physician Hospital Organization (PHO) – A contracting organization that requires physicians to use a specific hospital. In most cases, all hospital services, except for emergency and urgently needed services, must be obtained from the hospital with which your PCP is affiliated.

Plan Hospital – A hospital that has a contract with Harvard Pilgrim or your plan medical group or IPA to give you services and/or supplies.

Plan Medical Group – Physicians organized as a legal entity to provide medical care. The plan medical group has an agreement with Harvard Pilgrim to provide medical services to you.

Plan Pharmacy – A pharmacy that has an agreement with Harvard Pilgrim to provide you the medication(s) prescribed by your Plan Provider.

Plan Premium – The monthly payment to Harvard Pilgrim that entitles you to the Covered Services outlined in this Benefit Handbook. (Note: To qualify for the services outlined in this Benefit Handbook, you must also pay the monthly Medicare Part B Premium and, if applicable, Medicare Part A Premiums.)

Plan Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**plan providers**" when they are part of *First Seniority*. When we say that plan providers are "part of *First Seniority*," this means that we have arranged with them to coordinate or provide Covered Services to members of *First Seniority*. Harvard Pilgrim pays plan providers based on the contracts it has with the providers.

Prescription Drug Benefit Manager – Companies that contract with Medicare+Choice Organizations to manage pharmacy services.

Primary Care *Physician* (PCP) – A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing Covered Services while you are a plan member. Section 2 tells more about PCPs.

Prior Authorization – Approval in advance to get services. Some services are covered only if your doctor or other plan provider gets "prior authorization" from Harvard Pilgrim. Covered Services that need prior authorization are marked in the Benefits Chart.

Provider – A doctor, hospital, health care professional or health care facility licensed and/or certified by the State or Medicare to deliver or furnish health care services. See "Plan Provider", above.

Psychiatric Hospital – An institution providing inpatient psychiatric care for the diagnosis and treatment of mental illness that is certified by Medicare as a Psychiatric Hospital.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 10 for information about making complaints to the QIO.

Referral – Your PCP's approval for you to see a certain specialist or to receive certain Covered Services.

Rehabilitation Services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 7 for more information.

Rehabilitative Hospital – A Rehabilitative Hospital is a hospital authorized to care for Medicare beneficiaries that specializes in providing intensive rehabilitation services to its patients. For the purposes of this Benefit Handbook, a hospital will be considered a Rehabilitative Hospital if it is classified as a Rehabilitative Hospital under Medicare regulations (42 CFR Section 412.23 (b)).

Service Area – Section 2 tells about *First Seniority*'s service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Skilled Nursing Care – Services that can only be performed by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility (SNF) – A facility (or distinct part of a facility) which is primarily engaged in providing to its residents skilled nursing or rehabilitation services and is certified by Medicare. The term "skilled nursing facility" does not include a convalescent nursing home, rest facility or facility for the aged in which furnishes primarily custodial care, including training in routines of daily living.

Specialist – A doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (care for cancer patients), cardiologists (care for the heart), and orthopedists (care for bones).

"Three-Tier Prescription Drug List" – The Harvard Pilgrim "Three-Tier Prescription Drug List" is a list of medications for members and providers to reference regarding prescription drug coverage and applicable co-payments. This document includes Tier 1, 2 and 3 drugs, as well as information on prior authorization, excluded medications and quantity limitations/quantity-based co-payments. This document is updated annually and distributed throughout the year, upon request.

Urgently needed care – Section 3 explains about urgently needed services. These are different from emergency services.